

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

762 CERTIFICATE OF DEATH

Reg. Dist. No.

00757
773

Page 4

~~TO HOSPITAL OR ATTENDING PHYSICIAN:~~ The law requires that the death certificate be executed within 24 hours after death: Page 4
~~may be retained by the hospital or attending physician.~~

~~TO FUNERAL DIRECTOR:~~ After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Pages 1 and 2 should be filed.

~~Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.~~

~~Register prior to burial, cremation, or removal, and in any event within 72 hours after death.~~

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 30 YEARS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANATORIUM + HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First NELLIE	Middle GRACE	Last ABRECHT
4. DATE OF DEATH	Month JAN	Day 13	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Sept 1900
9. AGE (In years last birthday) 56	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT. STORE CLERK	10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	11. BIRTHPLACE (State or foreign country) FREDERICK, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME SAMUEL Tilton ABRECHT	14. MOTHER'S MAIDEN NAME BESSIE MOFFETT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 578-10-8774	17. INFORMANT Brother	Address TAKOMA PARK MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension / Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 32 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month Hour o. g. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/22 , 19 56 , to 13 JAN , 19 57 , that I last saw the deceased alive on 12 JAN , 19 57 , and that death occurred at 10:31 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE M.B. Queen M.D. ADDRESS (Street, city or town, state) 7112 Willow Ave 13 JAN DATE SIGNED Takoma Park Md. 19 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-15-1957	22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET Cemetery	22d. LOCATION (City, town, or county) Frederick - Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son	ADDRESS Frederick - Md.	24a. REC'D. BY REGISTRAR DATE 15 Jan 1957	24b. REGISTRAR'S SIGNATURE J. Wilson Dodge

BUREAU V. S

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

793

CERTIFICATE OF DEATH

Reg. Dist. No.

00758

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery Maryland		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 2 yrs.	
High Pt.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5900-Osceola Rd.		d. STREET ADDRESS 5900-Osceola Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Theima Virginia Adamson		Lost	4. DATE OF DEATH Jan. 9 1957
5. SEX F		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 11 th 1901		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY P.E.P. Co.	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles T. Lydon		14. MOTHER'S MAIDEN NAME Maud V. Sebastian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-05-0689	
17. INFORMANT No		Address Mary Adamson 5900 Osceola Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Prologue Pelvic Metastasis — (c) Nabigba.		INTERVAL BETWEEN ONSET AND DEATH 6 minute 3 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18/56, 19, to 1/10/57, 19, that I last saw the deceased alive on 1/8/57, 19, and that death occurred at 8:57 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE James A. O'Keeffe M.D. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 4747 Corin 17th and West DC DATE SIGNED	
22a. BURIAL, CREMATION, OR OTHER (Specify) BURIAL		22b. DATE THEREOF Jan. 12, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Mr. Oliver		22d. LOCATION (City, town, or county) Wash. D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lester J. Hanlon		ADDRESS 3831-GA Ave., N.W. 24a. REC'D BY REGISTRAR DATE 1/11/57	
		24b. REGISTRAR'S SIGNATURE L. H. Hedrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00759

791

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6½ Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5811 Kingswood Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin Barnwell		First	Middle	Last	AIKEN	4. DATE OF DEATH January 10 1957	Month Day Year
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1893		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wyatt AIKEN		14. MOTHER'S MAIDEN NAME Mary BARNWELL				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI WW2 None		17. INFORMANT (Wife) Charlotte AIKEN (Same as #2)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) an aneurism, aorta, dissecting DUE TO 451 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) arteriosclerosis, aorta DUE TO Hyper tensional Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Cndyf - Cndyf - Cndyf -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 January 1957 , to 10 January 1957 , that I last saw the deceased alive on 10 January 1957 , and that death occurred at 2130 PM , from the causes and on the date stated above. ACTUAL SIGNATURE H. E. Richardson M.D. U.S. Naval Hospital, Bethesda, Md. 1-11-57 PHYSICIAN'S NAME (Type) H. E. RICHARDSON, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.		ADDRESS (Street, city or town, state) DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 1-11-57		24b. REGISTRAR'S SIGNATURE George E. Passelly	

CERTIFICATE OF DEATH

170

BUREAU Y. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00760
21

795

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 Page 3 should be detached for use as the burial-travel period. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 East Melbourne Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) GRACE		First ELLEN	Middle ALLNUT
4. DATE OF DEATH JAN. 23	Month JAN.	Day 23	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/93
9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. FATHER'S NAME WILLIAM A. JACKSON	14. MOTHER'S MAIDEN NAME MAGGIE E. PARSLEY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Address Miss Florence Jackson, 416 East Melbourne Ave. Silver Spring, MD	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of uterus & metestasis</i> INTERVAL BETWEEN ONSET AND DEATH about 18 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 174X		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1952 to 23 Jan, 1957, that I last saw the deceased alive on 23 Jan, 1957, and that death occurred at 11 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) William D. Aud M.D. 906 Clarendon Rd., Silver Spring, MD DATE SIGNED 1/29/57			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) WILLIAM D. AUD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/26/57	22c. NAME OF CEMETERY OR CREMATORIUM MOUNT TABOR	22d. LOCATION (City, town, or county) (State) ETCHISON, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE 1/28/57
			24b. REGISTRAR'S SIGNATURE Frances Potter

BUREAU N.Y.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00761

Reg. Dist. No.

213

796

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Berwood RFD

c. LENGTH OF STAY IN 1b

6 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE **Maryland**

b. COUNTY **Montg.**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

d. STREET ADDRESS

Lincoln Park

e. IS RESIDENCE
ON A FARM?
YES NO

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Russell Nursing Home

3. NAME OF
DECEASED
(Type or print)

First
William

Middle

Last
Arnold

4. DATE
OF
DEATH

Month
Jan. Day
20, Year
1957

5. SEX

male

6. COLOR OR RACE

col.

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

March 4, 1900

9. AGE (In years
last birthday)

56

Yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Arnold

14. MOTHER'S MAIDEN NAME

Lizy Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

John Arnold

Address

Germantown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Vascular Accident

INTERVAL BETWEEN
ONSET AND DEATH

25 days

331X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

DUE TO

Hypertension

DUE TO

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

Frank J. Broschart

DATE SIGNED

EXAMINER'S
NAME (Type)

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Jan. 20, 1957

22a. BURIAL, CREMATION,
BURIAL (Specify)

1/24/57

22b. DATE THEREOF

Lincoln Park,

22d. LOCATION (City, town, or county)

Rockville, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert L. Swanson

ADDRESS

Rockville, Md.

24a. REC'D BY REGISTRAR

28 1957

24b. REGISTRAR'S SIGNATURE

Laurell Kraylor

WORLD EXHIBITION & CEMERCE OF EAST

BUREAU V. S.
RECEIVED
JAN 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

101762
212

Reg. Dist. No.

797

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Edward Ferry - Potomac R.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac</i>	
3. NAME OF DECEASED (Type or print) <i>Grace Keeler</i>		d. STREET ADDRESS	
First <i>Grace</i> Middle <i>Sister</i> Last <i>Keeler</i>		4. DATE OF DEATH <i>Jan 9 1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-22-23</i>	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) <i>33 yrs.</i>	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>0</i> Days <i>0</i>	
11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		12. Citizen of what country? <i>NSC</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		14. MOTHER'S MAIDEN NAME <i>Grace Keeler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>519-18-0796</i>	
17. INFORMANT <i>J. R. Boyd - Washington 20, DC</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Drowning</i>			
DUE TO (b) <i>Drowning</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Bethesda</i> (County) <i>Montgomery</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DATE SIGNED <i>Jan 9-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/13/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Monocacy</i>		22d. LOCATION (City, town or county) (State) <i>Bethesda</i> <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hallie</i>		ADDRESS <i>Bethesda</i>	
		24a. REC'D BY REGISTRAR <i>Charles W. Elgin</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles W. Elgin</i>	

BUREAU V. S.

AN 14 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00763

798

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page **I**
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
 filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page **2**
 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4301 Massachusetts Ave NW		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JOSEPH		Middle	Last BAILEY	4. DATE OF DEATH	Month January	Day 14	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1856		9. AGE (In years on birthday) 100	10. IF UNDER 1 YEAR Months 100	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME (?) Bailey		14. MOTHER'S MAIDEN NAME Charlotte (?)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lucile Hartmeyer		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Waukesha Clinic		20f. (City or town) Waukesha	(County) Wisconsin	
21. I certify that I attended the deceased from 1-19 , 19 56 , to 1-14 , 19 57 , that I last saw the deceased alive on 1-13 , 19 57 , and that death occurred at 644 M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Joseph A. Bailey</i>		M.D.		ADDRESS (Street, city or town, state) Waukesha Clinic		DATE SIGNED 1-18-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57		22c. NAME OF CEMETERY OR CREMATORIAL Prairie Home Cemetery		22d. LOCATION (City, town, or county) Waukesha (State) Wisconsin		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Hawkins Sons Washington, DC</i>		24a. REC'D BY REGISTRAR 1756 Pennsylvania Ave N		24b. REGISTRAR'S SIGNATURE <i>Beasie M. Thompson</i>		DATE 1-18-57		

BUREAU Y. S

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6
799

CERTIFICATE OF DEATH

(111764
217)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 406 Monroe Street Apt. #			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ella		First	Middle	Last	4. DATE OF DEATH Barkley	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/1918		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 19	12. IF UNDER 24 HRS Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard E. Parsley		14. MOTHER'S MAIDEN NAME BARBARA J. Wilson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Gaithersburg, Md.	(County) Montgomery Co.	(State) Md.	
21. I certify that I attended the deceased from Jan. 4, 1957 , to Jan. 6, 1957 , that I last saw the deceased alive on Jan. 6, 1957 , and that death occurred at 9 P.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) 26 N. Summit Ave., Gaithersburg, Md.		DATE SIGNED 1-6-57			
ACTUAL PHYSICIAN (Name & Type) Jack Schumacher, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cemetery	22d. LOCATION (City, town, or county) Gaithersburg, Md.	(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Reverend Number X		ADDRESS 1101 1/2 Number X	24a. REC'D BY REGISTRAR DATE 1-10-57	24b. REGISTRAR'S SIGNATURE Sertina R. Lovell					

BUREAU V. 2

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

800

CERTIFICATE OF DEATH

00765

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. LENGTH OF STAY IN lb <u>11 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>C. V. C 180 X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berkeley Gardens Sanitarium</u>		d. STREET ADDRESS <u>3113 Vinnett Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <u>Fannie</u>	Middle <u>G</u>	Last <u>Bell</u>	4. DATE OF DEATH	Month <u>Jan</u>	Day <u>26</u>	Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jul 18, 1871</u>	9. AGE (In years last birthday) <u>80 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 HRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judge Alexander J Brand</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Glenn Stewart</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>E. R. Clark, 3113 Vinnett Rd. Ch. Ch.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6th</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u>						6th	
DUE TO (c) <u>Arterosclerotic Heart Disease</u>						2 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>fall from bed</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bedroom</u>		20f. (City or town) (County) (State) <u>Montgomery</u>	
21. I certify that I attended the deceased from <u>26 Jan 1957</u> to <u>26 JAN 1957</u> that I last saw the deceased alive on <u>26 JAN 1957</u> , and that death occurred at <u>7 am</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>A. H. Richwine M.D.</u>						ADDRESS (Street, city or town, state) <u>5522 Western Ave 26</u>	
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/1957</u>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>St. Marys, Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Let...esca, A.d.</u>				24e. REC'D BY REGISTRAR <u>1-28-67</u>		24f. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. - Page 14
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Put the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X. 6

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

801

CERTIFICATE OF DEATH

00766

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2mos. 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 4501 44th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Louis	Middle Albert	Last BICKERTON	4. DATE OF DEATH January 14	Month Day Year January 14 19 57
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 23 December 1900	9. AGE (in years last birthday) 56	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Shop		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Harry Bickerton		14. MOTHER'S MAIDEN NAME Landonia Scroggins		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO WW-I	17. INFORMANT (Wife) Mrs. Ray D. Bickerton (Same As #2)	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Bronchogenic carcinoma INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 41: Rheumatic Heart Disease c Mitral Stenosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 Oct. 19 56 to 14 Jan. 57 , 19 56 , that I last saw the deceased alive on 14 Jan. 57 , 19 56 , and that death occurred at 3:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>J. T. Horgan</i>	M.D. U.S. Naval Hospital, Bethesda, Md. 1-15-57				
PATIENT'S NAME (Type) J. T. HORGAN, LT, MC, USN	U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-17-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey Funeral Home</i>		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR Tracy E. Casselly		
			24b. REGISTRAR'S SIGNATURE Tracy E. Casselly		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 17 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00767

802 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY			2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—NEAR ASHTON, MD.			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MERILEA NURSING HOME -14511 COLESVILLE ROAD			d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Bessie			First <i>Rice</i>	Middle <i>Blackwell</i>	Last <i>Blackwell</i>
4. DATE OF DEATH <i>Dec 19 1957</i>			Month <i>Dec</i>	Day <i>19</i>	Year <i>1957</i>
5. SEX FEMALE			6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-1856
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE --- RETIRED			10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) FREDERICKSBURG, VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ROBERT E. SMITH		
14. MOTHER'S MAIDEN NAME MARY JANE HOE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Attorney MR. GRIMES <i>413 N. Bend Road, Baltimore, MD.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Chronic bronchitis			INTERVAL BETWEEN ONSET AND DEATH 1 day 2 to 3 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic bronchitis		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-3 1957 to 1-10 1957 that I last saw the deceased alive on 1-7 1957 , and that death occurred at 6 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1917 Seminary Rd. Silver Spring, Md.					
DATE SIGNED John S. Rogers, M.D. 1957					
ACTUAL SIGNATURE John S. Rogers, M.D.		PHYSICIAN'S NAME (Type) John S. Rogers, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-12-57		22c. NAME OF CEMETERY OR CREMATORIAL THE CITY CEMETERY	
22d. LOCATION (City, town, or county) FREDERICKSBURG, VIRGINIA					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MARTIN W. HYSONG COMPANY INC. 1300 N. STREET, NORTHWEST WASHINGTON, D.C.					
24a. REC'D. BY REGISTRAR DATE 1957			24b. REGISTRAR'S SIGNATURE Gertrude Lawley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EURAU V. S

JAN 14 1967

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00768

803

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 42X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 7 Armour Green S.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle John	Suffix BLECLIC	4. DATE OF DEATH	Month January
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 17 January 1957	9. AGE (In years lost birthday) 00 yrs	IF UNDER 1 YEAR Months 00 Days 02 Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - -		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John P. BLECLIC		14. MOTHER'S MAIDEN NAME Grace A. MOORE		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT (Father) John P. BLECLIC Address same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] CENTRAL NERVOUS SYSTEM DAMAGE INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY EMBARRASSMENT ONSET AND DEATH 160.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Sub ARACHNOID HEMORRHAGE 23 Hours					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Jan 1957 to 18 Jan 1957 that I last saw the deceased alive on 18 Jan 1957 , and that death occurred at 1035P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>D. Shuptar</i>	M.D. U. S. Naval Hospital, Bethesda Md 1-19-57				
PHYSICIAN'S NAME (Type) D. SHUPTAR LT MC USN	U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>AT Pumphrey, 7557 Wisconsin Ave., Bethesda Md.</i>	ADDRESS <i>7557 Wisconsin Ave., Bethesda Md.</i>	24a. REC'D BY REGISTRAR 1-18-57		24b. REGISTRAR'S SIGNATURE <i>Brady L. Russell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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RECEIVED
BUREAU V. S.

JAN 25 1974

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00769

804

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS #4 Weaver Road, Fuller Hgts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ruth		First Ruth	Middle Ellen	Lost BOGERT	4. DATE DEATH 15 April 1947	Month January	Day 23	Year 19 57
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 15 April 1947	9. AGE (In years lost birthday) 7 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME John Marshal Bogert				14. MOTHER'S MAIDEN NAME Ruth Coleman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) John M. Bogert (Same As #2)				
Address Acute Lymphatic Leukemia								
INTERVAL BETWEEN ONSET AND DEATH 28 months								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 January, 1957 , to 23 January, 1959 , that I last saw the deceased alive on January 23, 1957 , and that death occurred at 09:55A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 1-23-57								
DATE SIGNED George J.A. Magnant								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) George J.A. Magnant, LT, MC, USN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Hall Funeral Home, Occoquan, Virginia				24a. REC'D BY REGISTRAR DATE 1-23-57				
				24b. REGISTRAR'S SIGNATURE Bruce Russell				

HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Please do not file this certificate with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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157

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00770
223

CERTIFICATE OF DEATH

Reg. Dist. No.

763

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium + Hosp		d. STREET ADDRESS 719 Midland Road	
3. NAME OF DECEASED (Type or print) Catherine Regina Bontz		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX Female	5. COLOR OR RACE Cauc.	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH 6-24-91
8. AGE (In years lost birthday) 65 yrs		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMPERTON Edward Samperton		14. MOTHER'S MAIDEN NAME Margaret E. Kane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-10-0803-A	
17. INFORMANT Old Record & patient-		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH sudden	
(b) Chronic Congestive Heart Failure			
DUE TO Generalized Arteriosclerosis		15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Chronic Thromboembolic Artery Disease	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28, 1957, to Jan 20, 1957, that I last saw the deceased alive on Jan 20, 1957, and that death occurred at 934 Ellsworth Dr. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Kenneth F. Laughlin M.D. 1-20-57	
ACTUAL SIGNATURE KENNETH F. LAUGHLIN		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/23/57	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Lumprey,		ADDRESS SILVER SPRING, MARYLAND REC'D BY REGISTRAR JAN 20 1957	
		24e. REGISTRAR'S SIGNATURE William Dodd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
805 CERTIFICATE OF DEATH

(0) 771

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 7807 Marion Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Francis	Middle Wheatley	Last BORDEN	4. DATE OF DEATH	Month January	Day 21	Year 19 57	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1869	9. AGE (In years last birthday) yrs. 86	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Samuel E. Wheatley				14. MOTHER'S MAIDEN NAME Virginia Hartley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) Sam W. Borden, Gibson Island, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, acute INTERVAL BETWEEN ONSET AND DEATH Less than 24 hrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 570.2		DUE TO (b) Gangrenous, small bowel loop		Unknown				
		DUE TO (c) Small bowel Obstruction, adhesions band		3 days.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Edema, Cardiac failure.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p.m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 20 January, 19 57 to 21 January, 19 57 , that I last saw the deceased alive on 21 January, 19 57 , and that death occurred at 09:00A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Bert C. Johnson							ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.	
PHYSICIAN'S NAME (Type) Bert C. Johnson, LCDR, MC, USN							DATE SIGNED 1-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-25-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery			22d. LOCATION (City, town, or county) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Lawler's Sons				ADDRESS 1726 Pennsylvania Ave., Washington, D.C.	24a. REC'D BY REGISTRAR 1-22-57		24b. REGISTRAR'S SIGNATURE Bert C. Johnson	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

764

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 39 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 4630 30th Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Maude	Middle Agnes	Last Bowman	4. DATE OF DEATH January 16	Month Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH II-1-89	9. AGE (In years (last birthday) 67 yrs.)	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Joseph T. Wade		14. MOTHER'S MAIDEN NAME Rose Abrams		12. CITIZEN OF WHAT COUNTRY? America	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure				INTERVAL BETWEEN ONSET AND DEATH 6 hours	
145x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last { b) DUE TO Cerebral edema (c) DUE TO Glioblastoma multiforme right frontal lobe				4 weeks + 6 months +	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 1946, to Jan 16 , 1957, that I last saw the deceased alive on 1-16-57 , 1957, and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i>		M.D. 934 Eggersworth Dr.		ADDRESS (Street, city or town, state) St. Louis & Spring Dr. DATE SIGNED 1-16-57	
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-14-57		22c. NAME OF CEMETERY OR CREMATORIAL Hickory Creek	
22d. LOCATION (City, town, or county) Louisville, Ky.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga Ave NW		24a. REC'D BY REGISTRAR 1/19/57	
				24b. REGISTRAR'S SIGNATURE F. Miller Jr. M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be stained by the hospital or attending physician on.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.
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JAN 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00773

806

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.		e. STREET ADDRESS 6606 Georgia Avenue, N.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Norman	Middle Cobden	Last Brown	4. DATE OF DEATH	Month January	Day 5	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11 July 1939	9 AGE (in years last birthday) 17 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Brown				14. MOTHER'S MAIDEN NAME Marcella Cobden				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the pre- existing cause last. (b) DUE TO (c) Unknown cause		gastric-intestinal hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 1d		
acute lymphatic leukemia						5 mos		
acute congestion of lungs						?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) acute congestive heart failure						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clinical Center	20f. (City or town) Hyattsville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 27 October, 1956 , to 5 January, 1957 , that I last saw the deceased alive on 5 January, 1957 , and that death occurred at 2:04 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Md. DATE SIGNED 1/5/57								
ACTUAL SIGNATURE <i>Emery C. Herman, Jr.</i>	M.D.							
PHYSICIAN'S NAME (Type) EMERY C. HERMAN, JR., M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 6/57	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Lebanon	22d. LOCATION (City, town, or county) Hyattsville (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		ADDRESS 3801-14st Wash. D.C.	24a. REC'D BY REGISTRAR DATE -8-57					
								24b. REGISTRAR'S SIGNATURE Beaice W. Thompson

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
						a. STATE Maryland	b. COUNTY Montg.		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
						d. STREET ADDRESS 8423 Piney Branch Rd.			
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stephen Lee Carter		First	Middle	Last	4. DATE OF DEATH Jan. 15, 1957	Month	Day	Year	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/2/52	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Myron Miron L. Carter		14. MOTHER'S MAIDEN NAME Ruth Shenk							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage							
8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Decompressed skull fracture (left)				2 days			
DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell or pushed from B & O RR bridge							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1/13/57 5:15 P.M. 10/23/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, 120ft. City or town) factory, street, office bldg., etc.) Burlington Ave. Silver Spring Montg. Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 15, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORIUM CARVER MEMORIAL CEMETERY		22d. LOCATION (City, town, or county) BELTSVILLE, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey, SILVER SPRING, MD.</i>		ADDRESS		24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Wilson Dodd</i>			

RECEIVED
BUREAU V.

JAN 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00775

807

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 55 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 608 Taylor Run Parkway		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Alfred	Last CAREY	4. DATE OF DEATH January 31 1957	Month January	Day 31	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-24-1882	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Daniel F. Carey				14. MOTHER'S MAIDEN NAME Sarah Mc Cormick				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Sp. Am. & WW-I		17. INFORMANT (Daughter) Mrs. Louise C. Bastion (Same As #2)		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction, old & recent.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>due to Atherosclerotic Heart Disease</i> DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Renal Disease, cerebral thrombosis</i></p> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U.S. Naval Hospital, Bethesda, Md.	(County) 2-1-57	(State)
<p>21. I certify that I attended the deceased from 7 Dec., 1956, to 31 Jan., 1957, that I last saw the deceased alive on 31 Jan., 1957, and that death occurred at 5:55 P.M. from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.</p> <p>DATE SIGNED 2-1-57</p> <p>ACTUAL SIGNATURE <i>K. Mc Carthy.</i></p>								
PHYSICIAN'S NAME (Type) R. J. Mc Carthy, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines</i>		ADDRESS 2901 14th St., N.W., Washington, D.C.	24a. REC'D BY REGISTRAR 2-1-57	24b. REGISTRAR'S SIGNATURE <i>Frank E. Tandy</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU X

FEB 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00776

808

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2Rt. 1, Germantown		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Hobart	Middle McKinley	Last Case	4. DATE OF DEATH	Month January	Day 22	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9/8/98	8. AGE (In years last birthday) 58 yrs	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Hours 0	11. IF UNDER 24 HRS. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Case				14. MOTHER'S MAIDEN NAME Nancy Hyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not no. or unknown) No		16. SOCIAL SECURITY NO. 237-26-6087		17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Hypertension INTERVAL BETWEEN ONSET AND DEATH 4 months							
44DX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)		DUE TO					
} (c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6 , 19 56 , to Aug. 22 , 19 57 , that I last saw the deceased alive on Aug. 22 , 19 57 , and that death occurred at 10:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED 1957							
ACTUAL SIGNATURE J. Schumacher M.D.							
PHYSICIAN'S NAME (Type) J. Schumacher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Salem Methodist		22d. LOCATION (City, town, or county) Cedar Grove, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elm L. Polksworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE 1-24-57		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

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BUREAU V. S.

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

DEATH CERTIFICATE: This certificate should be completed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the PMJ, or prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 1/2 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.		f. STREET ADDRESS 1712 M Street N.E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Priscilla		First	Middle	Last	4. DATE OF DEATH Casey	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 1909	9. AGE (In years at birthday) 88	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 47 yrs.	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Columbia, South Carolina		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Robert Days		14. MOTHER'S MAIDEN NAME Eliza Johnson								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sister Nellie Jackson		526 14th Street N.E. Washington, D. C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH 45 minutes		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident										
DUE TO 21X										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension								5 years		
DUE TO b)										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Walking up flight of stairs and fainted								
20c. TIME OF INJURY Hour 12:30		Month, Day, Year 1 23 1957	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Chevy Chase		(County) Montgomery	(State) Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 2-23-57								
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BUR AL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Columbia, South Carolina		22d. LOCATION (City, town, or county) Columbia, South Carolina				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Stewart</i>		ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR AN 28 1957		24b. REGISTRAR'S SIGNATURE Beaver Thompson				

RECEIVED
BUREAU V. S.

JAN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

810

CERTIFICATE OF DEATH

01778

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY	Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg R.F.D.		c. LENGTH OF STAY IN 1b	1 year	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION	Nicholson Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First Charlotte	Middle -	Last Chamblin	4. DATE OF DEATH	Month 1	Day 19	Year 1957
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5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Mar. 19, 1875	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Loudoun Co. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John Chamblin	14. MOTHER'S MAIDEN NAME Mollie Burson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mason Chamblin 1000 N. Daniels St., Arlington, Va.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH
diseased - Cranial Hemorrhage		Years
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b)		
Diseased Arteriosclerosis		years
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 16, 1956 to June 19, 1956, that I last saw the deceased alive on June 16, 1957, and that death occurred at 10 AM, from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		

ACTUAL SIGNATURE Jack Schumacher	DATE SIGNED Jun 19, 1957
PHYSICIAN'S NAME (Type) Jack Schumacher M.D.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-22-57	22c. NAME OF CEMETERY OR CREMATORI Chestnut Grove Cemetery	22d. LOCATION (City, town, or county) Herndon, Va. (State)
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23. FUNERAL DIRECTOR'S SIGNATURE G. Berkley Green - Herndon, Va.	ADDRESS	24a. REC'D BY REGISTRAR DATE Jun 19, 1957	24b. REGISTRAR'S SIGNATURE Absentee U. Coyle
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00779

811 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrells,									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS Forrest Hills Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Joe	Middle Arthur	Last CHANCE, Sr.	4. DATE OF DEATH	Month January	Day 17	Year 1957						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 18 Jan. 1892	9. AGE (In years at birth) 84 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Lee Andrew Chance				14. MOTHER'S MAIDEN NAME Mary Etta Yates									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 413 07 5349		17. INFORMANT (Son) Joe Arthur Chance, Jr. (Same As #2)		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Carcinoma of Lung, Widely Metastatic, over 6 mos.</i>								INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.	Month Dec.	Day 11	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that I attended the deceased from 11 December, 1956 , to 17 January, 1957 , that I last saw the deceased alive on 17 January, 1957 , and that death occurred at 1:05 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>T.S. Dunn</i>								DATE SIGNED					
PHYSICIAN'S NAME (Type) T.S. Dunn, Jr., LT, MC, USN								M.D. U.S. Naval Hospital, Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-57		22c. NAME OF CEMETERY OR CREMATORIUM Olive Hill Cemetery		22d. LOCATION (City, town, or county) Savannah, Tennessee		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>		ADDRESS 857 Wisconsin Ave., Bethesda, MD		24a. REC'D BY REGISTRAR 1-17-57		24b. REGISTRAR'S SIGNATURE <i>George E. Passally</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

BUREAU V.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00780

786

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i> Rockville Life		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville		Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DOVER Road	'DOVER Rd.		
3. NAME OF DECEASED (Type or print)	First <i>MARIHA</i>	Middle <i>P.</i>	Last <i>CHASE</i>
4. DATE OF DEATH	Month <i>JAN.</i>	Day <i>18</i>	Year <i>1957</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-16-1884</i>
9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>11 d.</i>	11. IF UNDER 24 HRS Days <i>Hours</i>	12. IF UNDER 24 HRS Hours <i>Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	
11. BIRTHPLACE (State or foreign country) <i>Id.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Douglas Pountre</i>		14. MOTHER'S MAIDEN NAME <i>Millie (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>Insurance Form</i>		Address <i>DOVER RD Brother - George Pountre Rockville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		CEREBRAL THROMBOSIS ARTERIOSCLEROSIS	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NONE</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>RD 1, Gaithersburg, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 1956</i> to <i>Death</i> , that I last saw the deceased alive on <i>Dec. 23 1956</i> , and that death occurred at <i>10:00 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Clive E. Jackson</i> , M.D. PHYSICIAN'S NAME (Type) <i>Clive E. Jackson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/12/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lincoln Park</i>
22d. LOCATION (City, town, or county) <i>Rockville, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Swanson - Rockville, Md.</i>		24d. REC'D BY REGISTRAR <i>Laurel Dragtorpe</i>	24b. REGISTRAR'S SIGNATURE <i>Laurel Dragtorpe</i>
		DATE <i>9-2-1957</i>	

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00781

812

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 19918 Woodburns Road	
3. NAME OF DECEASED (Type or print) MARjorie Louise		First Christie	Middle L
4. DATE OF DEATH Month 1 Day - 30 Year 1957		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11-13-24	
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 55 Days 0 Hours 0 Min 0	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Burton P. Williams		14. MOTHER'S MAIDEN NAME MARIAN CARSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. no	
17. INFORMANT Rachel CARSON (aunt)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right lower lobe pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus (b) DUE TO (c) DUE TO	
19. MEDICAL CERTIFICATION Diabetes Mellitus ; heart block undit. cause		20. INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour 6 p.m. 1957	
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington Place	
20f. (City or town) Washington, DC		(County) Montgomery County (State) MD	
21. I certify that I attended the deceased from July 1952 to Jan 30 1957 , that I last saw the deceased alive on Jan 29 1957 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Michel M. Healy		ADDRESS (Street, city or town, state) Washington Place, Washington, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		22d. LOCATION (City, town, or county) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Werner G. Pumphrey		24a. REC'D BY REGISTRAR Silver Spring, Md.	
ADDRESS Silver Spring, Md.		DATE 2-1-57	
24b. REGISTRAR'S SIGNATURE Bruce W. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

813

CERTIFICATE OF DEATH

111782

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page _____ should be detached for use as the burial/transit permit. Then please remove carbon paper. Page _____ and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 84 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Clara	Middle Virginia
4. DATE OF DEATH		Month January	Day 6
5. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		Colored	
7. IMMEDIATE CAUSE (a)		8. DATE OF BIRTH March 1st. 1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Lawson Butler		14. MOTHER'S MAIDEN NAME Nancy Welch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
George Clagett, Barnesville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		Cerebral Vascular accident, left hemiplegia Hypertensive-Arteriosclerotic Vascular Disease 14 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 1952 to 6 January 1952 , that I last saw the deceased alive on 5 January 1952 , and that death occurred at 11 1/2 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Barnesville, Md. 7 Jan 52	
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 7 Jan 52	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/57	
22c. NAME OF CEMETERY OR CREMATORIALy Friendship		22d. LOCATION (City, town, or county) Damascus Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wilma B. Miller Barnesville Md.		24a. REC'D BY REGISTRAR DATE 1/8/57	
		24b. REGISTRAR'S SIGNATURE Charles W. Edgin	

BUREAU V.

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

814

CERTIFICATE OF DEATH

00783

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
MONTGOMERY MARYLAND		Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
KENSINGTON KENSINGTON GARDENS SANITARIUM		Kensington					
d. NAME OF HOSPITAL (If not in the public give street address) OR INSTITUTION	e. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
GARDENS SANITARIUM	3403 Oberon Street						
3. NAME OF DECEASED (Type or print)	First NELLIE	Middle WALKER	Last CLEPHANE	4. DATE OF DEATH	Month 1	Day 7	Year 1957
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 4, 1868	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walker		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT John W. Clephane, 3403 Oberon St.,		Address Kensington, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Bacillus pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days			
Fractured left hip (head of femur)		34 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in bathroom, fracturing left femur.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 4 1956 4 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home Kensington-Montgomery Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1956, to Jan 7, 1957, that I last saw the deceased alive on Jan 7, 1957, and that death occurred at 8:40 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		May 1957		1635 Drury St. N.W.			
PHYSICIAN'S NAME (Type)		Aloysius J. Connolly M.D.		Washington 10, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Nichols & Sons		1750 Pennsylvania Ave NW Washington, DC		24a. REC'D BY REGISTRAR DATE 10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

Coroner notified & will
approve Jan 7th 1957

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File No. 815

815

CERTIFICATE OF DEATH

Reg. Dist. No.

111784
214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck	c. LENGTH OF STAY IN 1b 13 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) / / / /					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		d. STREET ADDRESS Rt. 1 Silver Spring,					
3. NAME OF DECEASED (Type or print)	First John	Middle	Last Collins				
4. DATE OF DEATH	Month January	Day 6	Year 1957				
S. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/80	9. AGE (In years from birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saundersville, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Collins		14. MOTHER'S MAIDEN NAME Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO. 240 09 6394		17. INFORMANT Bradford Rest Home		Address Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Pulmonary Edema Cardiorenal Decomp.				INTERVAL BETWEEN ONSET AND DEATH days	
44 x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
DUE TO		(c)		Cardiorenal Hypertension with Edema		1yr.	
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suprapubic prostatectomy with indwelling catheter						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Norbeck	(County) Montgomery	(State) Md.
21. I certify that I attended the deceased from Dec. 19, 1955 to Jan. 6, 1957, that I last saw the deceased alive on Jan. 5, 1957, and that death occurred at 6:40 P.M. from the causes and on the date stated above. A. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Webster Sewell M.D. DATE SIGNED Physician's Name (Type) Webster Sewell, M.D. 1/6/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-10-57	22c. NAME OF CEMETERY OR CREMATORIUM Piney Woods - Frederick	22d. LOCATION (City, town, or county) Montgomery Rd	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS 467 N st. n.w.	24a. REC'D BY REGISTRAR DATE 1/11/57	24b. REGISTRAR'S SIGNATURE Frances Potters			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00785

816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Md Mont 214	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Kensington	1 Mo	Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Kensington Garden Sanitarium		9810 Grayson Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
John W			Colton
4. DATE OF DEATH	Month	Day	Year
	1	-	7 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1 - 19 - 76
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
80 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired		Insurance	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Milwaukee Wis		Milwaukee Wis	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)			
17. INFORMANT		Address	
Col George S. Levenson		Jug - 0378	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage	
42.1 DUE TO		Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		years	
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18 1956 to 10/19 1957 that I last saw the deceased alive on 10/5 1957, and that death occurred at 2:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Charles M. Weber</i>		DATE SIGNED 12600 PARKLAND DR. Rockville MD 11/1/57	
PHYSICIAN'S NAME (Type) <i>Charles M. Weber</i>		22d. LOCATION (City, town, or county) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-9-57	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Glenwood Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances Potter		ADDRESS 4812 Galena Ave	
24a. REC'D BY REGISTRAR DATE 1-12-57		24b. REGISTRAR'S SIGNATURE Frances Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the record, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 16 1957

RECEIVED

20786
214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

817

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
<i>Montgomery</i>		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			
<i>Kensington</i>		<i>life</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>4000 Lawrence Ave.</i>					
3. NAME OF DECEASED (Type or print)		First	Middle		
<i>Francis</i>		<i>Gregory</i>	<i>Conley</i>		
4. DATE OF DEATH		Month	Day		
		<i>Jan</i>	<i>30</i>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
male		white			
8. B. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.		
<i>Oct 21 1936</i>		<i>3</i>	<i>9</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>D.C.</i>		<i>USA</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>Edward S. Conley</i>		<i>Omelia Spitzer Conley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.			
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fulminant Sarcoido-tuberculosis</i> - <i>secondary</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>bronchitis</i>			
		DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Constipation, Enlarged Thymus</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
19					
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1-30-57</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>2/2/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. OLIVET CEMETERY</i>		22d. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey,</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>1/31/57</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Collier</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

BUREAU V. S.

FEB 5 1970



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

818

CERTIFICATE OF DEATH

011787

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i> MARYLAND		a. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural, Gaithersburg</i>	<i>life</i>	<i>Gaithersburg</i> d. STREET ADDRESS <i>Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
First <i>Mary</i> Middle <i>Virginia</i> Last <i>Connors</i>	4. DATE OF DEATH Month <i>January</i> Day <i>24</i> Year <i>1957</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct-12-1896</i> AGE (in years last birthday) yrs. <i>69</i> 87 Months <i>3</i> Days <i>12</i> Hours <i>0</i> Min. <i>0</i>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-sewing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Rockville, Md. Route 1</i>
13. FATHER'S NAME <i>Erasmus West</i>		14. MOTHER'S MAIDEN NAME <i>Betty Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Martha E. Cockrham, Gaithersburg, Md. R-3</i> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensitivity</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>7-Brooklawn, Gaithersburg, Md.</i> (County) <i>Montgomery</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan-17-1957</i> to <i>Jan-24-1957</i> , that I last saw the deceased alive on <i>Jan-23-1957</i> , and that death occurred at <i>3:44 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>William C. Miller</i> PHYSICIAN'S NAME (Type) <i>W. C. MILLER, M.D.</i> ADDRESS (Street, city or town, state) <i>7-Brooklawn, Gaithersburg, Md.</i> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/26/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Oak</i>
22d. LOCATION (City, town, or county) <i>Gaithersburg, Md.</i>		22d. LOCATION (City, town, or county) <i>Gaithersburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>1-25-57</i>	24b. REGISTRAR'S SIGNATURE <i>Alvinda G. Cooke</i>

BUREAU V. S

JAN 22 1962

REGISTRATION
EXPIRES 1962

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 0117886

819

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

7 months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

driveway-4527 Rosedale Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Bethesda

d. STREET ADDRESS

4527 Rosedale Avenue

e. IS RESIDENCE
ON A FARM?
YES NO

**3. NAME OF
DECEASED
(Type or print)**

First
Thomas

Middle
A.

Last
COVER

4. DATE
OF
DEATH

Month
January

Day
9

Year
19 57

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

52

yr.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED

June 27, 1904

Months
6

Days
12^{1/2}

Hours
Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Employee

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy-Civilian

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles E. Cover

14. MOTHER'S MAIDEN NAME

Anne Baublitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Harriet Cover- Same Item #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Frank J. Broschart

M. D.

DATE SIGNED
M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

January 9th 1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF
Burial 1/12/1957

22c. NAME OF CEMETERY OR CREMATORIUM
Prospect Hill

22d. LOCATION (City, town, or county)
Washington

(State)
D. C.

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE-10-57

24b. REGISTRAR'S SIGNATURE

Bessie M. Thompson

BUREAU Y. S.

May 5 1957

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File No. 21-789

Reg. Dist. No.

11789
217

820

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #1 Rockville		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Frank	Middle Montgomery	Last Crown	4. DATE OF DEATH January 27 1957	Month January	Day 27	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH March 3, 1877	P. AGE (in years lost birthday) 79⁰ yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter; Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Crown		14. MOTHER'S MAIDEN NAME Virginia Ricketts						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-05-5822		17. INFORMANT George W. Crown- Rockville, Md. Address 410 Reading Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. CONGESTIVE HEART FAILURE 15 YEARS						INTERVAL BETWEEN ONSET AND DEATH 5 YEARS		
(b) DUE TO HYPERTENSION 15 YEARS								
(c) DUE TO ARTERIOSCLEROSIS 15 YEARS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 24 1957 to January 27 1957 , that I last saw the deceased alive on January 27 1957 , and that death occurred at 8:18A M , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Donald K. Rosenberger</i> M.D. ADDRESS (Street, city or town, state) 2611 Summit St. Gaithersburg, Md. DATE SIGNED Jan. 27, 1957 PHYSICIAN'S NAME (Type) Dr. G.S. Rosenberger								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30-57		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak		22d. LOCATION (City, town, or county) Gaithersburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Humphrey</i>		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE / - 29-57		24b. REGISTRAR'S SIGNATURE <i>Gertude P. Lawler</i>		

QUEEN V. E

3 3 1957

THE AMERICAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

821

CERTIFICATE OF DEATH

Reg. Dist. No. 1011780

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>45 minutes</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>		d. STREET ADDRESS <i>14601 Willard Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>J. D.</i>	Middle <i>J.</i>	Last <i>Darlington</i>	4. DATE OF DEATH Month <i>Jan.</i>	Day <i>4</i>	Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 11, 1885</i>	9. AGE (in years last birthday) yrs. <i>71</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY <i>Booker T. (Retired) Do-it</i>				11. BIRTHPLACE (State or foreign country) <i>Alabama</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>George Johnston</i>				14. MOTHER'S MAIDEN NAME <i>Martha Darlington</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>000-00-0000</i>			
17. INFORMANT <i>Eleanor A. Darlington</i>				Address <i>14601 Willard Ave., Chevy Chase, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6306 Wisconsin Ave.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/5</i> , 19 <i>55</i> , to <i>1/4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/4</i> , 19 <i>57</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6306 Wisconsin Ave.</i> DATE SIGNED <i>J. L. Marks</i>							
ACTUAL SIGNATURE <i>J. L. Marks</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Dr. I. L. Marks</i> 6306 Wisconsin Ave., Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 7, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>5103 Wisconsin Ave.</i>		22d. LOCATION (City, town, or county) (State) <i>Allendale, South Carolina.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chevy Chase Funeral Home</i>				ADDRESS <i>5103 Wisconsin Ave.</i>			
24a. REC'D BY REGISTRAR <i>147-57</i>				24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the original prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. 3

JAN 10 1957

DEGELEV E.O.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00791
216

CERTIFICATE OF DEATH

Reg. Dist. No.

822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Page 2 should be filed with the record or prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>20 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Silverman Hospital</i>		d. STREET ADDRESS <i>1412 Rhode Island Ave. N.W.</i>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>HELEN</i>	Middle <i>Miles</i>	Last <i>Davis</i>	4. DATE OF DEATH <i>6/25 PM</i>	Month <i>JAN</i>	Day <i>- 25</i>	Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>01/01/1895</i>	9. AGE (In years last birthday) <i>67 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Editor, Chemist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Miles Henry R.</i>		14. MOTHER'S MAIDEN NAME <i>Ketcham, Charles</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-48-9153</i>		17. INFORMANT <i>Mrs. Helen Davis - Blouse - L. 217-2</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		Mc metastatic carcinoma (telson) Schirrheus grade II Breast carcinoma (the primary)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>March</i> , 19 <i>56</i> , to <i>Jan 25</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Jan 25</i> , 19 <i>57</i> , and that death occurred at <i>6:57 P.M.</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Washington, D.C.</i>					DATE SIGNED <i>4/25/57</i>
ACTUAL SIGNATURE <i>Michel M. Healy</i>									
PHYSICIAN'S NAME (Type) <i>Michel M. Healy</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1/29/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		ADDRESS <i>2901 14th St., N.W. DC</i>		Wash. REC'D BY REGISTRAR <i>JAN 28 1957</i>		24. REGISTRAR'S SIGNATURE <i>Beaure Thompson</i>			

BUREAU V.

AN 28 1957

REGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 217
00792

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital		d. STREET ADDRESS R.F.D. Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Titus Deets		First Titus	Middle Deets	Last Day	4. DATE OF DEATH Jan. 20	Month Jan.	Day 20	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1898	9. AGE (In years lost birthday) 58	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 8	Hours 0	Min. 0
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operated a general store		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lewisdale, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Titus W. Day		14. MOTHER'S MAIDEN NAME Rosa B. King						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-3461		17. INFORMANT Mrs Hilda L. Day, Monrovia, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage, large, basal				INTERVAL BETWEEN ONSET AND DEATH 4 hours		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost		(b) Arterio-sclerosis, generalized				?		
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost		(c) Hypertension, marked obesity				?		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Browningsville, Md.		(County) Baltimore Co. (State) Md.
21. I certify that I attended the deceased from June 1955 , to 1/20/57 , 19, that I last saw the deceased alive on 1/20/57 , 19, and that death occurred at 5:15 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Damascus, Maryland								
DATE SIGNED 1/21/57								
ACTUAL SIGNATURE <i>G. F. Meadors, M.D.</i>		M.D. Damascus, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Bethesda		22d. LOCATION (City, town, or county) Browningsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Molesworth</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR 1-29-57		24b. REGISTRAR'S SIGNATURE <i>Seslinda B. Lawler</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UREAU V. S.

JAN 28 1957

RECEIVED

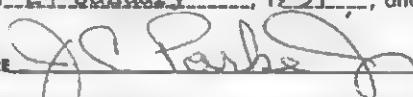
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

824

CERTIFICATE OF DEATH

00793
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 527 Alexander Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First SKINNER, Jr.	Middle (nnn)	Last Donald	4. DATE DEATH January 24 1957	Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1-17-57	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Donald Skinner		14. MOTHER'S MAIDEN NAME Joyce L. Brown		12. CITIZEN OF WHAT COUNTRY/ U.S.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father, Donald Skinner (Same as #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonia INTERVAL BETWEEN ONSET AND DEATH 60 hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause last. } DUE TO (c) Prematurity						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 17 January, 1957 to 24 January, 1957 , that I last saw the deceased alive on 24 January, 1957 , and that death occurred at 10:55A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-25-57						
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) J.C. PARKE, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-30-57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Eugene E. Murray, Jr. W.H. Bacon, 1722 7th St., N.W. Washington, D.C.		ADDRESS 10512 X V.	24a. REC'D BY REGISTRAR 1-25-57 24b. REGISTRAR'S SIGNATURE Bruce O. Russell			

REINHOLD Y. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00794

825

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) /X/ Lexington Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS Promerantz Trailer Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lewis	Middle Joseph	Last DRAWDY	4. DATE OF DEATH Month January	Day 28	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1-27-57	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jack William DRAWDY				14. MOTHER'S MAIDEN NAME Viola Lillian Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Jack W. Drawdy (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 Primary Atelectasis DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH 32 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U.S. Naval Hospital, Bethesda, Md.	(County)	(State)
21. I certify that I attended the deceased from 27 Jan. , 1957, to 28 Jan. , 1957, that I last saw the deceased alive on 28 Jan. , 1957, and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) J.C. PARKE, Jr. LT MC USN DATE SIGNED 1-29-57							
ACTUAL SIGNATURE 							
PHYSICIAN'S NAME (Type) J.C. PARKE, Jr. LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR 1-29-57	24b. REGISTRAR'S SIGNATURE James E. Russell		

RECEIVED
BUREAU Y. S.

JAN 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00795

826

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 6812 Conn. Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7006 Brookville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES Martin		First	Middle	Last	4. DATE OF DEATH January 13 1957	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 31, 1881	9. AGE (In years lost birthday) 75 yrs	10. IF UNDER 1 YEAR Months 12	11. IF UNDER 24 HRS. Days 12	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Artist		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME James M. Eiker		14. MOTHER'S MAIDEN NAME Agnes Strobel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur M. Eiker-Item # 1		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 7 days				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary Artery Sclerosis		Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5516 Neb. Ave. D.C.		20f. (City or town) Washington, D. C.		(County) D.C. (State) D.C.
21. I certify that I attended the deceased from January 9, 1957 to January 13 1957 , that I last saw the deceased alive on January 11 1957 , and that death occurred at 11:54 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 5516 Neb. Ave. D.C. DATE SIGNED 1-13-57								
ACTUAL SIGNATURE Robert B. Havell		M.D.						
PHYSICIAN'S NAME (Type) Robert B. Havell M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek		22d. LOCATION (City, town, or county) Washington, D. C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1/15/57		24b. REGISTRAR'S SIGNATURE Bennie W. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
LIBRARIES N.Y.C.

JAN 17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

827

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE W. D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3403 Wheeler Road, S. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Bertha	Middle Aline	Last Eldred	4. DATE OF DEATH January 2,	Month Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1874	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William I. Winne		14. MOTHER'S MAIDEN NAME Jane Godwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> followed by cause unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Synthetic oil clogging of fuel filter</i> (c) <i>lungs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Generalized arteriosclerosis with myocardial infarction</i>					
INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Arteriosclerosis with myocardial infarction</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 20, 1956, to January 2, 1957, that I last saw the deceased alive on January 2, 1957, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert W. Weiger</i> PHYSICIAN'S NAME (Type) Robert W. Weiger, M. D. M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Leis Cemetery	
22d. LOCATION (City, town, or county) Washington DC					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 1-5-57		24b. REGISTRAR'S SIGNATURE Berrie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X.

JAN 8 1957

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

101797

828

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>District of Columbia</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>5425 Conn. Ave.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dorothy Ann Emerson</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year <i>1 - 21 1957</i>	Month	Day Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-23-10</i>		9. AGE (in years last birthday) <i>46 yrs.</i>	10. IF UNDER 1 YEAR Months <i>7</i> Days <i>28</i>	11. IF UNDER 24 HRS. Hours <i>7</i> Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Banking</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>FRANK B. CROVO, Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Beckstein</i>				Address <i>Bethesda Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Aubrey (brother)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure & Intestinal Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH <i>70 hours</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>8287 Georgia Ave Silver Spring Md</i>		20f. (City or town) <i>Washington</i>	(County) <i>D. C.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Nov</i> , 19 <i>47</i> , to <i>Jan 21</i> , 19 <i>57</i> that I last saw the deceased alive on <i>January 20</i> , 19 <i>57</i> , and that death occurred at <i>120 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>8287 Georgia Ave Silver Spring Md</i>						DATE SIGNED <i>Jan 25 1957</i>	
ACTUAL SIGNATURE <i>Aaron H. Traum</i>		M.D. <i>8287 Georgia Ave Silver Spring Md Jan 25 1957</i>							
PHYSICIAN'S NAME (Type) <i>Aaron H. Traum</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 26</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek</i>		22d. LOCATION (City, town, or county) <i>Washington</i>		(State) <i>D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey, Bethesda, Md.</i>		ADDRESS						24a. REC'D BY REGISTRAR DATE <i>1-23-57</i>	
								24b. REGISTRAR'S SIGNATURE <i>Bethesda 1-23-57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please refile carbon papers. Page 1 and 2 should be filed with the original prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNLAD Y. S.

JAN 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
82 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOLERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 9212 LONG BRANCH PARKWAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9212 LONG BRANCH PARKWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RAY		First F.	Middle FEHRMAN	Last JAN	Month 4	Day 19	Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JULY 7, 1906	9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SENIOR COUNSELLOR #		10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL BETHESDA-CHEVY CHASE		11. BIRTHPLACE (State or foreign country) CINCINNATI, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FEHRMAN				14. MOTHER'S MAIDEN NAME KATE RICKEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 402-38-3574		17. INFORMANT Mrs. Ernestine H. Fehrman, 9212 Long Branch Pkwy Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH Swaddling			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4.25.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CAUSE OF DEATH.							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCHEART				DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1-4-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 1/7/57		22b. DATE THEREOF 1/7/57		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON MEM. PARK CEMETERY CINCINNATI, OHIO		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Lumprey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1-8-57	
						24b. REGISTRAR'S SIGNATURE L. L. L. L.	

MORTALITY MEDICAL EXAMINER: This certificate should be executed within hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO THE DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00799

Reg. Dist. No. 216

830

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Kensington		Kensington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
3215 McComas Ave.		3215 McComas Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
	FLOYD	ROOSEVELT	FUNKHOUSER			
4. DATE OF DEATH	Month	Day	Year			
	Jan.	20	1957			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years seit birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 22, 1907	19 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
wash. San. Comm.		Clerk		Virginia		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
THOMAS FUNKHOUSER		SARAH MOOMAN		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
		578-10-5352		ELLA A. FUNKHOUSER		ITEM 1 12
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> "caus." DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
(State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED JAN. 20. 1957		
EXAMINER'S NAME (Type) DR. FRANK J. BROSCHEART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57		22c. NAME OF CEMETERY OR CREMATORIUM George Wash. Cemetery		22d. LOCATION (City, town, or county) Prince George Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1-23-57		24b. REGISTRAR'S SIGNATURE <i>Bessie S. Hart, J. Fox</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the form PM3.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

831

CERTIFICATE OF DEATH

Reg. Dist. No.

00800
218

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<u>MONTGOMERY</u> MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
f. STREET ADDRESS <u>107 Indian Spring Dr.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERNARD K. GANNON</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1957</u>	
S SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 77</u>
9. AGE (In years lost, birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Timothy Gannon</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. McAdoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wife - above</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<u>541.0</u> DUE TO <u>Cardiac Decompensation</u> INTERVAL BETWEEN ONSET AND DEATH <u>About 1 yr</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hemorrhage from Duodenal ulcer</u> 5-8 yrs 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9006 Wisconsin Rd</u>
20f. (City or town) <u>Silver Spring</u>		(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>31 Jan</u> to <u>28 Jan</u> 1957, that I last saw the deceased alive on <u>28 Jan</u> 1957, and that death occurred at <u>10:45 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u>		ADDRESS (Street, city or town, state) <u>9006 Wisconsin Rd</u> DATE SIGNED <u>28 Jan '57</u>	
PHYSICIAN'S NAME (Type) <u>William D. Aud</u>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 1-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie W. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please affix carbon papers. Page 4 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FFB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

766

CERTIFICATE OF DEATH

Reg. Dist. No.

00801
223

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4473 District of Columbia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 1110 Aspen Street N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leo	Middle (None)	Last Garner	4. DATE OF DEATH January 20	Month Day Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-88	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min. Address
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Europe	
13. FATHER'S NAME Lewis Garner		14. MOTHER'S MAIDEN NAME Fannie ?		12. CITIZEN OF WHAT COUNTRY? America	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
No		-----		-----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO 7 day					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Spasmodic DUE TO 3 years					
(c) Arteriosclerosis Heart Disease DUE TO 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/13 , 19 57 , to 1/20 , 19 57 , that I last saw the deceased alive on 1/19 , 19 57 , and that death occurred at 3:45 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Alvin I Kay DATE SIGNED 1/20/57					
ACTUAL SIGNATURE		NAME (Type)			
22c. BURIAL, CREMATION, REMAINS (Specify) Burial 1/22/57		22b. DATE THEREOF 1/22/57		22c. NAME OF CEMETERY OR CREMATORIUM DAI ISRAEL CEM OVENTHILL	
22d. LOCATION (City, town or county) OVENTHILL MD				(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Palmer		ADDRESS Funeral Home 4217-9th St. NW DC		24a. REC'D BY REGISTRAR DATE 1/22/57	
				24b. REGISTRAR'S SIGNATURE J. Wilson Rock	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

767

CERTIFICATE OF DEATH

011802

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7800 Baltimore Ave.	
e. STREET ADDRESS 2609 Fairlawn St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HELEN	Middle R.	Last GIBBONS
4. DATE OF DEATH	Month Jan.	Day 15,	Year 1957
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1897
9. AGE (in years lost birthday) yrs 59		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. BIRTHPLACE (State or foreign country) Iowa		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Rogell		14. MOTHER'S MAIDEN NAME Ida May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-30-7235	
17. INFORMANT Augustas Gibbons		Address 1129 N.H. Ave. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (bones-liver) DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Carcinoma of breast (c)		INTERVAL BETWEEN ONSET AND DEATH 14 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.n. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Jan. 15 , 19 56 , that I last saw the deceased alive on Jan. 15 , 19 57 , and that death occurred at 2 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Paul N. Taylor		ADDRESS (Street, city or town, state) 2140 Pa. Ave. N.W. Wash. D.C. 1-15-57	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/57	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gribis Son		ADDRESS 1756 Pa. Ave. NW, DC	
24a. REC'D BY REGISTRAR 1/16/57		24b. REGISTRAR'S SIGNATURE J. Miller, D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00803

CERTIFICATE OF DEATH

832

Reg. Dist. No. 114

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	MARYLAND LENGTH OF STAY (In this place) 8:00 pm 1/23/57	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	Florida Miami Beach
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS 5730 LaGorce Drive 4545 Concourse Dr.		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
MRS. EDNA L. GIBSON		Jan 24 1957	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-28-91
9. AGE last birthday 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Walter J. Hearns		14. MOTHER'S MAIDEN NAME Ellen Kitchenman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Edith Sarah 4545 Concourse Dr.		18. MEDICAL CERTIFICATION Cerebral Hemorrhage Hypertension	
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4-5 days 15-18 yrs 5-6 days	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bronchitis, acute			
19b. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946, to 24 Jan 1957, that I last saw the deceased alive on 23 Jan 1957, and that death occurred at 7:10 AM, from the causes and on the date stated above. SIGNATURE William D. Caud M.D. 9006 Edgewater Rd. Delray 1/24/57 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Ship & burial		DATE THEREOF Jan. 28, 1957	NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery
24. REC'D BY REGISTRAR DATE 1-26-57		REGISTRAR'S SIGNATURE Beulie M. Thompson	LOCATION (City, town, or county) Miami Beach, Florida
25. FUNERAL DIRECTOR'S SIGNATURE Warren E. Murphy, Inc.		ADDRESS 8434 Georgia Ave 3rd Street Garage	

UNEXAU V. S

JAN 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001804

Item 8. (6-210) 24592

833 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPENCERVILLE		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPENCERVILLE	
d. STREET ADDRESS Rancho		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle A	Last Gibson
4. DATE OF DEATH	Month JAN	Day 17	Year 1952
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 29, 1845
9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Carpentry	11. BIRTHPLACE (State or foreign country) SPENCERVILLE, MD	12. CITIZEN OF WHAT COUNTRY? LES 4
13. FATHER'S NAME John W. Gibson	14. MOTHER'S MAIDEN NAME Annie Eliza Pierce	Address 1111 Maryland Avenue, Baltimore, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 219-07-9383	17. INFORMANT Mrs. Jessie Gibson	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 14 , 1952, to Jan 14 , 1952, that I last saw the deceased alive on Jan 16 , 1952, and that death occurred at 1111 Maryland Avenue, Baltimore, Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant	M.D.	ADDRESS (Street, city or town, state) Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) A. D. Bonifant	DATE SIGNED 1/19/52		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF JAN 17, 1952	22c. NAME OF CEMETERY OR CREMATORIAL Dixie Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore - Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gertrude Lowberg	ADDRESS 6101 18th Street N.W.	24a. REC'D BY REGISTRAR DATE JAN 18, 1952	24b. REGISTRAR'S SIGNATURE Gertrude Lowberg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 18 1957

REGEVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

834

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00805

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 84 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
3. NAME OF DECEASED (Type or print) Richard Winston		First Middle Last Giroux	4. DATE OF DEATH Month Year January 7, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1908
9. AGE (In years last birthday) 48 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Records Administrator	10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Michigan	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Henry Giroux		14. MOTHER'S MAIDEN NAME Anna Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal carcinoma of both lungs</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) metastases to both adrenals, both 11 mos.</i> DUE TO <i>(c) kidneys and multiple bones</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 15, 1956 , to January 7, 1957 , that I last saw the deceased alive on January 7, 1957 , and that death occurred at 11.22 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward J. Laskowski, M.D.</i>	ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1/7/57
PHYSICIAN'S NAME (Type) Edward J. Laskowski, M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1-10-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat. Cem	
22d. LOCATION (City, town, or county) Arlington		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE 8-57	24b. REGISTRAR'S SIGNATURE Bessie Thompson

RECEIVED
FEBRUARY 1957

JAN 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00806

835 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5710 Aberdeen Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Eleanor		First	Middle	Last	4. DATE OF DEATH GOODMAN	Month January	Day 31	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 23 Sept. 1889	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Easom PORTCH		14. MOTHER'S MAIDEN NAME Lucy TURNER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 226 18 4300		17. INFORMANT (Son) Boris N. Goodman (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carc (M.O. M.C., Cervix with metastases)				INTERVAL BETWEEN ONSET AND DEATH Unknown		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 22 Nov. 1956, to 31 Jan. 1957, that I last saw the deceased alive on 30 Jan. 1957, and that death occurred at 1:21 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Arthur J. Johnson, M.D. U.S. Naval Hospital, Bethesda, Md. 1-31-57								
PHYSICIAN'S NAME (Type) Arthur J. Johnson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-4-57		22c. NAME OF CEMETERY OR CREMATORI Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS 1551 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-31-57		24b. REGISTRAR'S SIGNATURE Brayton C. Bassett		

BUREAU V. S

RECEIVED
FEB 4 1964

001807

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
836 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>MONTGOMERY</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. STREET ADDRESS <i>Silver Spring 10002 Forest Grove Drive</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Grace Theresa</i>		First	Middle	Last	4. DATE OF DEATH <i>Grant 1 10 1957</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/18/83</i>		9. AGE (In years lost birthday) <i>73 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>2</i> Days <i>22</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - - - -</i>		11. BIRTHPLACE (State or Foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>John C. Dougherty</i>		14. MOTHER'S MAIDEN NAME <i>Helen Hamilton</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Husband - son</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Postoperative Shock</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Intraabdominal Hemorrhage</i>		(c) <i>Solid Carcinoma of the Ovary, Bilateral.</i>					
DUE TO		DUE TO		DUE TO					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>					
21. I certify that I attended the deceased from <i>June 1953 to June 10, 1957</i> , to <i>June 10, 1957</i> , that I last saw the deceased alive on <i>Sept 10, 1956</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED					
ACTUAL SIGNATURE <i>Philip A. Caulfield</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Philip A. Caulfield, M.D.</i>		2701 Conn. Ave. N. W., Wash. D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/14/1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) <i>Washington</i>		(State) <i>D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>DATE 12-57</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00808	
7682 FilmSeq 9-25-57 et CERTIFICATE OF DEATH										Reg. Dist. No. 773	
1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hyattsville									
c. LENGTH OF STAY IN 1b 1 month											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM (DCA)		d. STREET ADDRESS 108 Fox St									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Glenn	Middle Jeffrey	Last Ross	4. DATE OF DEATH January	Month 19	Day 19	Year 1957			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-13-56	9. AGE (In years lost birthday) yrs. Months	IF UNDER 1 YEAR <input checked="" type="checkbox"/>	IF UNDER 24 HRS <input checked="" type="checkbox"/>	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Gross, Mr. Phillip		14. MOTHER'S MAIDEN NAME Esther Badt									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. 1st Chart		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Encephalitis (autopsy finding) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Gastroenteritis, mod. + to (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hours									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from Jan 18, 1957, to Jan 19, 1957, that I last saw the deceased alive on Jan 18, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)	DATE SIGNED Maynard J. Cohen, M.D. 2412 Weston Dr. Silver Spring, Md 1/19/57
ACTUAL SIGNATURE Maynard J. Cohen, M.D.		PHYSICIAN'S NAME (Type) MAYNARD J. COHEN									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORIUM Ohev Shalom Cem		22d. LOCATION (City, town, or county) DC		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Maynard J. Cohen		ADDRESS 4217 9th St. N.W.		24a. REC'D BY REGISTRAR DATE 1/22/1957		24b. REGISTRAR'S SIGNATURE J. Wilson Ladde					

BUREAU V. S

JAN 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

787

CERTIFICATE OF DEATH

00809

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE						
<i>Montgomery Rockville Md</i>		Md						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY						
<i>Rockville</i>		Md						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<i>106 Lynch St.</i>		<i>Rockville</i>						
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>Bertha</i>				<i>May</i>	<i>5</i>	<i>18</i>	<i>1957</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Female</i>	<i>White</i>	<i>WIDOWED</i> <input type="checkbox"/> <i>DIVORCED</i> <input type="checkbox"/>	<i>Oct 1, 1900</i>	<i>56 yrs</i>	Months	Days	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Housewife</i>		<i>Home</i>		<i>Russia</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>Tiger Charlick</i>		<i>Reba</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
						<i>Samuel Grossman - Same</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH		
<i>Cerebral Hemorrhage</i>						<i>2 1/2 yrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO						
<i>Diabetes mellitus</i>		<i>Cerebral Hemorrhage</i>						
DUE TO								
<i>Generalized arteriosclerosis</i>								
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
		<i>Diabetes mellitus</i>						
20c. TIME OF INJURY	Month,	Day,	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour o. m. p. m.				White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				
19								
21. I certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
<i>Actual Signature</i>				<i>M.D.</i>		<i>Brothers & Brothers Ct Rockville Md</i>		
PHYSICIAN'S NAME (Type)								
<i>H.C. Shapiro MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORI	22d. LOCATION (City, town, or county)					
<i>Burial</i>	<i>Jan 7/57</i>	<i>Anshei Emunah</i>	<i>Baldo, Md</i>					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE				
<i>Sol Leivinson & Bro Inc 1124-26 N.</i>		<i>North Ave</i>	<i>JAN 9 1957</i>	<i>Lawell Krugman</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 9 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been submitted by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

788

CERTIFICATE OF DEATH

00810

Reg. Dist. No. 276

1. PLACE OF DEATH

COUNTY Montgomery

CITY (If outside corporate limits, write RURAL
OR
and give nearest town)

TOWN Rockville

MARYLAND

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Waverly Sanitorium

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE DC

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Washington

STREET
ADDRESS

(If rural give location)

5401 16th Street NW

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

Mary

E.

Guy

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

Female

White

Widowed

Oct 5, 1857

9. AGE last birthday

99

IF UNDER 1 YEAR

Months Days Hours Min.

(Year)

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

George Alexander Bohrer

14. MOTHER'S MAIDEN NAME

Catherine Otterback

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

No

5401 16th St NW

Walter B. Guy Washington, DC

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

4 days

ANTECEDENT CAUSE(S)

DUE TO

Chronic passive congestive

2 wks.

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

Myocardial failure

2 wks.

(C)

Generalized arteriosclerosis

2 wks.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 19.50, to ... Jan. 9, 19.57, that I last saw the deceased

alive on ... Jan. 9, 19.57, and that death occurred at 11 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

1/12/57

NAME OF CEMETERY OR CREMATORIUM

Rock Creek Cemetery

LOCATION (City, town, or county)

Washington DC

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 1-11-57

1756 Pennsylvania Ave NW Washington, DC

Bessie M. Thompson

1957

JUN 15 1957

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00811

837

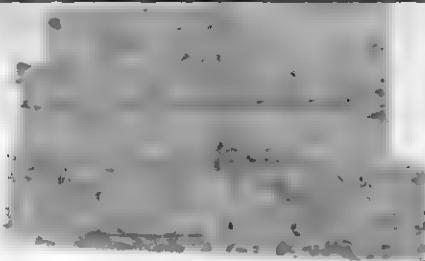
CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2309 Garrison Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Florence	Middle Koppelman	Last Haimes	4. DATE OF DEATH January	Month 10,	Day 1957	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH October 6, 1915	9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Aide		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Koppelman				14. MOTHER'S MAIDEN NAME Sophia Dorman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 565-38-8633		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Tumor involvement of liver 6 mos				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Widespread bone involvement with rib fractures				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 2, 1957 , to January 10, 1957 , that I last saw the deceased alive on January 10, 1957 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE <i>John Laszlo</i>		M.D.		DATE SIGNED 1/11/57			
PHYSICIAN'S NAME (Type) John Laszlo, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-57		22c. NAME OF CEMETERY OR CREMATORIAL United Hebrew		22d. LOCATION (City, town, or county) Bethesda Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Joe 2100 Eutaw Pl		ADDRESS DANIELO		24a. REC'D BY REGISTRAR DANIELO		24b. REGISTRAR'S SIGNATURE Bessie Thompsons	

IN ATTENDING PHYSICIAN
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this certificate may be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death. Page 4



BUREAU V. S

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

769

CERTIFICATE OF DEATH

111812
2/14

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 7307 TAKOMA AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WEPPIE	Middle I.	Last HAISLIP
4. DATE OF DEATH Month Jan	Day 28	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 22, 1876
9. AGE (In years (at birth) 80 yr.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Housewife	12. BIRTHPLACE (State or foreign country) Virginia
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME CATHERINE J. COURTYN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 4111 E. Superior St.	17. INFORMANT MARGARET H. WENDLANDT	Address Bethesda, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2/24 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterio - Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio - Thrombosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day Not while at work <input type="checkbox"/>	Year of work <input type="checkbox"/>
20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) 6911 5th st. N.W.	(County) D.C.
(State) 1957			
21. I certify that I attended the deceased from Dec 18, 1953 to Jan 28, 1957 , that I last saw the deceased alive on Jan 27, 1957 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. B. LITTLE			ADDRESS (Street, city or town, state) 6911 5th st. N.W.
PHYSICIAN'S NAME (Type) A. B. LITTLE MD			DATE SIGNED Jan 28/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 31, 1957	22b. DATE THEREOF Jan 31, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek	22d. LOCATION (City, town, or county) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home 4812 Gaean NW	ADDRESS Deaf Funeral Home 4812 Gaean NW	24a. REC'D. BY REGISTRAR DATE 1/31/57	24b. REGISTRAR'S SIGNATURE Frances Kotter

RECEIVED
BUREAU V. S.

FEB 5 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

838

CERTIFICATE OF DEATH

00813

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Margaret	Middle M	Last Hall
4. DATE OF DEATH	Month January	Day 1	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23-1976
9. AGE (In years lost <input type="checkbox"/> day) yrs. 80		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Phillip Dutrow		14. MOTHER'S MAIDEN NAME Achsah Dutrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Hall, Poolesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cerebral softening		4 months	
DUE TO (b) Cerebral and General Arteriosclerosis		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 June, 1950 , to 1 Jan, 1957 , that I last saw the deceased alive on 3 Dec, 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Gordon M. Smith M.D. ADDRESS (Street, city or town, state) BARNESVILLE DATE SIGNED 2 Jan 57			
PHYSICIAN'S NAME (Type) GORDON M. SMITH,		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/57	
22c. NAME OF CEMETERY OR CREMATORIAL Monocacy		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville, Md		ADDRESS	
24a. REC'D BY REGISTRAR DATE 14/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin per Dr. Elgin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be reigned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

BUREAU V.

JAN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

839

CERTIFICATE OF DEATH

00814

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		d. STREET ADDRESS 3419 N St., N. W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lansington Garden Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Josephine	Middle Louise	Last Halloran	4 DATE OF DEATH Jan. 31st.	Month Jan.	Day 19	Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 1883		9. AGE (in years lost birthday) 73 yrs	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Theodore Horn				14. MOTHER'S MAIDEN NAME Minnie Reinhart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Minnie Keyers 1821 Jackson St., N.E., D.C.			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. Branchopneumonia									INTERVAL BETWEEN ONSET AND DEATH 5 Days.
DUE TO Corcinoma puerorum									2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (City or town) (State)			
21. I certify that I attended the deceased from alive on 21 Jan 1957 , and that death occurred at 21 Jan 1957 , that I last saw the deceased M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chesapeake Wash. D.C.		DATE SIGNED Charles Thompson							
ACTUAL SIGNATURE Charles Thompson		PHYSICIAN'S NAME (Type) Charles Thompson							
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 2/2/57		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill		22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Buckley		ADDRESS 3034 L St. N.W., D.C.		24a. REC'D BY REGISTRAR 2-2-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
 filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2
 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

13 5 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00815

840

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 25 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL (If not in hospital, give other address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.		d. STREET ADDRESS 5105 Ardmore Way	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Leroy	Middle Joseph	Last Hart
4. DATE OF DEATH January 26	Month	Day	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 23, 1936
9. AGE (In years last birthday) 20 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument maker		10b. KIND OF BUSINESS OR INDUSTRY Instrument Making	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clayton Hart		14. MOTHER'S MAIDEN NAME Grace Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 219-32-6496	
17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week	
Septicemia Acute myelogenous Leukemia		1 week	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1957, to January 26, 1957, that I last saw the deceased alive on January 26, 1957, and that death occurred at 5:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE GURSTON GOLDIN, M.D. PHYSICIAN'S NAME (Type) GURSTON GOLDIN, M.D. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 1/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/57	
22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rudk 5305 Harford Road. #14		24a. REC'D BY REGISTRAR DATE JAN 29 1957 24b. REGISTRAR'S SIGNATURE Pearl Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

770

CERTIFICATE OF DEATH

00816
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>District Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 16th Mol.</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>MARY LOVE K. Hathaway</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year 1 - 9 1957
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-3-83</i>	9. AGE (In years last birthday) <i>73 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min. 12 - 9 - 0 - 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Indiana</i>	
13. FATHER'S NAME <i>ELBERT</i> <i>Albert Kessler</i>		14. MOTHER'S MAIDEN NAME <i>Emma Hogan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Mrs. Helen Hathaway 3620 16th St</i>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i>				[INTERVAL BETWEEN ONSET AND DEATH] <i>terminal</i>	
3.31X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO <i>Cerebral Accident</i>				3 years	
(c) DUE TO <i>Atherosclerosis Hypertension</i>				? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Inanition</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 1954</i> , to <i>Jan 9 1957</i> , that I last saw the deceased alive on <i>Jan 9 1957</i> , and that death occurred at <i>10115th</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert A. Hare</i> ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i> DATE SIGNED <i>1-10-57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 1/12/57		22b. DATE THEREOF <i>1/12/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>OAKLAWN CEMETERY</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner E. Pumphrey, Inc. 3434 Ga Ave, SS</i>		ADDRESS <i>1 Werner E. Pumphrey, Inc. 3434 Ga Ave, SS</i>		24a. REC'D BY REGISTRAR DATE <i>1/11/57</i>	
				24b. REG. STAR'S SIGNATURE <i>William Redd</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNAU V. G.

IAN 2 1957

RECEIVED

00817

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 213

841

1. PLACE OF DEATH a. COUNTY Rachaelix Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD#4	c. LENGTH OF STAY IN TB life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD # 4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tilden Lane		f. STREET ADDRESS Tilden Lane			
3. NAME OF DECEASED (Type or print) Rachael		First Hawkins	Middle Lott		
4. DATE OF DEATH Jan 19, 1957	Month Jan	Day 19	Year 19		
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1885		
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 71 yr.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Weasley Green		14. MOTHER'S MAIDEN NAME Elmira Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT		
		Address Lilly McRoy 510 Bickford Ln. Rockville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Found dead in bed					
420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan 20, 1957		
EXAMINER'S NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/23/57	22c. NAME OF CEMETERY OR CREMATORIAL Haiti	22d. LOCATION (City, town, or county) (State) Rockville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sonder</i>	ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 1/23/57 24b. REGISTRAR'S SIGNATURE <i>Lowell Langston</i>		

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5-7 may be retained by the funeral director. Fill pages 1 and 2 with the information prior to burial, cremation, or removal.

FEDERAL BUREAU OF INVESTIGATION

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00818
27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		842 MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 1931 ETON ROAD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IN WOODS - MANCHESTER ROAD						<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GEORGETTE	Middle ANNE	Last HENTGEN	4. DATE OF DEATH JAN. 14 1957	Month JAN.	Day 14	Year 19 57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH SEPT. 10, 1941	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN R. HENTGEN		14. MOTHER'S MAIDEN NAME GRACE OTIS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT POLICE RECORDS, SILVER SPRING, MARYLAND		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE AND CONTUSION INTERVAL BETWEEN ONSET AND DEATH found dead								
X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURE OF SKULL (rt) in woods								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) undetermined						
20c. TIME OF INJURY Month, Day, Year Hour <input type="radio"/> a.m. <input checked="" type="radio"/> p.m. 1/14 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 1/15/57						
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/18/57		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner L. Humphrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1/15/57		24b. REGISTRAR'S SIGNATURE <i>Frederick J. Broschart</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the ~~PM3~~ or removal.

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 1, 2, 3, 4, 5, 6, 7

843

CERTIFICATE OF DEATH

Reg. Dist. No.

00819

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore Bethesda

c. LENGTH OF STAY IN lb
RURAL and give nearest town)

2 1/2 Mo.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

Rockville Pike

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
JohnMiddle
JosephLast
HIGGINS4. DATE
OF
DEATH
Nov. 20 1957Month
JanDay
1
Year
19 57

5. SEX

6. COLOR OR RACE

Male

Cauc

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 20 1898

9. AGE (In years
last birthday)

58 5/11

10. IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mariner

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy

11. BIRTHPLACE (State or foreign country)

Connecticut

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Joseph HIGGINS

14. MOTHER'S MAIDEN NAME

Helen BURKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

Yes

If yes, give war or date of service)

WWI WWI

16. SOCIAL SECURITY NO.

7 11 05 81 49

Mrs. John D. HIGGINS (Wife)

17. INFORMANT

621 N. Montford Ave., Baltimore, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Lymphosarcoma

INTERVAL BETWEEN
ONSET AND DEATH
Year & half

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I attended the deceased from

1 Jan 1957, to 1 Jan 1957, that I last saw the deceased

alive on 1 Jan 1957,

and that death occurred at 0645 M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Biagio A. CONTE

M.D. U. S. Naval Hospital, Bethesda, Md. 1-1-57

PHYSICIAN'S
NAME (Type)

Biagio A. CONTE

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

Burial

1-5-57

Oaklawn

Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
John A. MILLERADDRESS
2334 Jefferson St., Baltimore24a. REC'D BY REGISTRAR
DATE24b. REGISTRAR'S SIGNATURE
Frances E. Russell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNEAU A. S.

" 1957

BRUNEAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00820

844

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Montgomery MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY Mont.	
RURAL Kensington	5 wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Kensington Garden Sanitarium		7400 Bybrook Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nancy	Middle Blanche	Last Holme
4. DATE OF DEATH	Month 1	Day 3	Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-13-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Hw-		Home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Illinois		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry Kerr		Mary Pervi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No --		None	
17. INFORMANT		Address	
Mrs H.W. Bitting		(Daughter) 014-3616	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure (acute)	
450.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		years	
DUE TO (b) Arteriosclerosis Generalized		years	
DUE TO (c) Senility - 83		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/15/57, 19, to 11/15/57, 19, that I last saw the deceased alive on 11/13/57, 19, and that death occurred at 1:20 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Samuel Allen		DATE SIGNED 11/15/57	
PHYSICIAN'S NAME (Type)		M.D. (Dr. K. Kyngburgh has been attending patient)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Ir.		22b. DATE THEREOF 1-5-57	
22c. NAME OF CEMETERY OR CREMATORIAL Mayfield Mem. Cem.		22d. LOCATION (City, town, or county) Macoupin Co. Ill	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE - 10-57		24b. REGISTRAR'S SIGNATURE Bevrie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGIESTRANT

JAN 15 1981

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821

845

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 hr. 5 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 7905 Randor Road		f. DATE OF DEATH January 23, 1957		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	h. LOST HOMMEL	i. MONTH January	j. DAY 23	k. YEAR 1957	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 22, 1957	9. AGE (In years lost birthday) yrs 1	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 5	12. CITIZEN OF WHAT COUNTRY? U.S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland			
13. FATHER'S NAME Robert E. HOMMEL				14. MOTHER'S MAIDEN NAME Eugenia KIRK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Robert Hommel (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 762.5 DUE TO Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause last. (b)							
DUE TO (c) Immaturity (24 wks gestation)							
INTERVAL BETWEEN ONSET AND DEATH 1 hr 05 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 January, 1957 , to 23 January, 1957 , that I last saw the deceased alive on 23 January, 1957 , and that death occurred at 12:27 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED James C. Parke M.D. 1-23-57							
ACTUAL SIGNATURE James C. Parke M.D. 1-23-57							
PHYSICIAN'S NAME (Type) James C. Parke, Jr., LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. B. Humphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-23-57 24b. REGISTRAR'S SIGNATURE Bray C. Stanley	

EXCELSIOR

1901

1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111822

771

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE	
<i>Montgomery</i> MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Takoma Park 12</i>		<i>Montgomery</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		<i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Washington Sub. & Hosp. 104</i>		<i>3704 Evertin St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Girl</i>	Middle <i></i>	Last <i>Hoover</i>
4. DATE OF DEATH	Month <i>1</i>	Day <i>31</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/31/57</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>7</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Herbert Paul Hoover	Pauline Thorpe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>		Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Atletasias & Pneumonia</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	Day <i></i>	Year <i></i>
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i> (State) <i></i>
21. I certify that I attended the deceased from <i>1-31</i> , 19 <i>57</i> , to <i>1-31</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-31-57</i> , 19 <i>57</i> , and that death occurred at <i>12:55 P.M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i></i>			
DATE SIGNED <i>2/1/57</i>			
ACTUAL SIGNATURE <i>Warren G. Preissner M.D.</i>			
PHYSICIAN'S NAME (Type) <i>WARREN G. PREISSNER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 2-1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lee Washington Cemetery</i>	22d. LOCATION (City, town or county) <i>Bethesda - Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cecilia Walter - 254 Carroll St NW</i>		24a. ADDRESS <i></i>	24b. REGISTRATION NUMBER <i>1957 J Wilson Dodd</i>
VS A15 (4) 15M 9/55		24c. REC'D BY REGISTRAR <i>J Wilson Dodd</i>	24d. DATE <i>1752</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. A.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00823

846

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital			e. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) Julius			First	Middle	Last
4. DATE OF DEATH January 14, 1957			Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/85	
9. AGE (In years lost birthday) 71 yrs			10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Lucy Hopkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (See, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) DUE TO (c)			<i>Congestive heart failure Bronchopneumonia bldnd</i>		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Healed myocardial infarction</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at 10:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>C. H. Ligon, M.D.</i>			DATE SIGNED <i>1/17/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORIUM Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Swanson</i>			24a. REC'D BY REGISTRAR DATE 1/19/57	24b. REGISTRAR'S SIGNATURE <i>Gertrude B. Lawler</i>	
ADDRESS Rockville, Md.					

RECEIVED
BUREAU V. S.

JAN 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

847

CERTIFICATE OF DEATH

Reg. Dist. No.

00824

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9005 FAIRVIEW ROAD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) RANDE		d. STREET ADDRESS 9005 FAIRVIEW ROAD	
4. DATE OF DEATH JAN. 15 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/81
9. AGE (In years by birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker - Own home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Hoem		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. John E. Horsley, 9005 Fairview Road		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		INTERVAL BETWEEN ONSET AND DEATH IV MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CHRONIC PYELONEPHRITIS		DUE TO HANY YRS.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 15, 1954, to JAN 15, 1957, that I last saw the deceased alive on JAN 15, 1947, and that death occurred at 5:25 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE JACK J. RHEINGOLD M.D. ADDRESS (Street, city or town, state) 1307 18th ST, N.W. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57	
22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 1/17/57		24b. REGISTRAR'S SIGNATURE John H. Hause, M.D.	

TO HOSPITAL ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

AN 21 1957

REGULATIVE

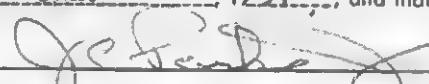
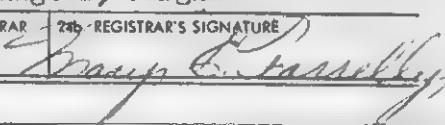
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00825

848

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 6729 Fairfax Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Judith Lynn HOYT		First	Middle	Last	4. DATE OF DEATH January 28 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH 1-24-57	9. AGE (in years last birthday) yrs. 3	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 3	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Carl Dean HOYT		14. MOTHER'S MAIDEN NAME Shirley Mills						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Carl Dean Hoyt (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Prematurity At Vertex						INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Prematurity								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 24 Jan. , 19 57 , to 28 Jan. , 19 57 , that I last saw the deceased alive on 28 Jan. , 19 57 , and that death occurred at 2:21A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE  ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 1-28-57. DATE SIGNED								
PHYSICIAN'S NAME (Type) J. C. PARKE, JR.LT,MC, USN		M.D. U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington		(State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS 1-28-57		24a. REC'D BY REGISTRAR 1-28-57	24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. A. V. M. I.

1955 - Nov.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

849

CERTIFICATE OF DEATH

Reg. Dist. No.

00826
216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington		d. STREET ADDRESS 3021 Ferndale Street Carroll Hall		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3021 Ferndale Street Carroll Hall				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CLARE		First RAYMOND	Middle HUGHES	Lost	4. DATE OF DEATH January 11, 1956	Month Jan	Day 11	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Sept. 20, 1878	9. AGE (in years last birthday) 78 yrs	10. IF UNDER 1 YEAR Months 3			IF UNDER 24 HRS Days 1b
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Acct.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Jennie ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John C. Hughes Item # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Myocardial failure INTERVAL BETWEEN ONSET AND DEATH 24 hours								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Pulmonary edema.			48 hours			
		DUE TO (c) Pulmonary emphysema			10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 15, 1951 to Jan 11, 1956 , that I last saw the deceased alive on Jan 11, 1957 , and that death occurred at 903 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 3935 Baltimore St., Kensington, Md. DATE SIGNED 3/11/57								
ACTUAL SIGNATURE Thomas A. Hindman		PHYSICIAN'S NAME (Type) Thomas A. Hindman						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/14/57		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		22d. LOCATION (City, town, or county) Prince George Co., Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24e. REC'D BY REGISTRAR DATE -12-07		24f. REGISTRAR'S SIGNATURE Benjamin Thompson		
VS A15 (4) 15M 9/55								

REGEV V. A.

JAN 15 1957

REGEV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111827

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 32 Hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS T3500 Grenoble Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First James	Middle Joseph	Last Hughes	4. DATE OF DEATH January	Month Day Year 22 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-23-91	9. AGE (in years lost, birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Library of Congress	11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Edward Hughes		14. MOTHER'S MAIDEN NAME Ellen Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I Army	17. INFORMANT Hospital Records	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
DUE TO Ischemic infarct of Pons					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)					
DUE TO Thrombosis of basilar artery					
(c) Arteriosclerosis					
INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Diabetes mellitus, hypertension					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21 , 1957, to Jan 22 , 1957, that I last saw the deceased alive on Jan 21 , 1957, and that death occurred at 5:50 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 7600 Carroll Ave, Tak Jan 22/57					
DATE SIGNED Raymond O. West					
ACTUAL SIGNATURE					
PHYSICIAN'S NAME (Type) RAYMOND O. WEST					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/25/57	22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CEMETERY	22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren L. Lumpley,		ADDRESS SILVER SPRING, MD.	24. REC'D BY REGISTRAR JAN 4 1957	25. REGISTRAR'S SIGNATURE F. Wilson Dill	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

LEGAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00828

Reg. Dist. No. 23

773

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		d. STREET ADDRESS 8217 18th Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Newton		First	Middle	Last	4. DATE OF DEATH January 22 1957	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-78	9. AGE (In years last b. thday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME John William Hummer				14. MOTHER'S MAIDEN NAME Mary Elizabeth Keene				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Clair Hess (son-in-law) W. Hyattsville Md.		Address 8217 18th Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary hemorrhage from old tubercular cavity (ct) audience</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic pulmonary tuberculosis with cavitation?</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>1-22-57</i>			
EXAMINER'S NAME (Type) <i>Frank J. Broschart</i>								
22a. BURIAL, CREMATION, REMOVAL (specify) <i>Cremation</i>	22b. DATE THEREOF <i>Jan 25, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Res Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Bellino Broschart Co 300 - 4th St. N.W.</i>	ADDRESS		24a. REC'D BY REGISTRAR <i>J. Nelson</i>		24b. REGISTRAR'S SIGNATURE <i>J. Nelson</i>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REAU V.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

850

CERTIFICATE OF DEATH

00829

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 7		d. STREET ADDRESS 4527 Rock Spring Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res m o 57-21 Grosvenor Lane						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HARRY B		First	Middle	Last	4. DATE OF DEATH January 26	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1881	9. AGE (In years last birthday) 8-19-1883 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Writer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) U.S. INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Russell Hunt		14. MOTHER'S MAIDEN NAME Corrine Haynes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT LILLY R. HUNT, LILY R. SAME		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerosis, generalized (c)		Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH Approx 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-16, 1957 , to 1-26, 1957 , that I last saw the deceased alive on 1-25, 1957 , and that death occurred at 3:10 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Robert M. Dimmette, M.D. ADDRESS (Street, city or town, state) 9710 Brixton Lane, Bethesda, Md. DATE SIGNED Jan 26, 1957								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-1957		22c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cem.		22d. LOCATION (City, town, or county) ALEXANDRIA, VA.		
23. FUNERAL DIRECTOR'S SIGNATURE Jes. E. Mullings		ADDRESS 1752 Pa. Ave. NW		24a. REC'D BY REGISTRAR DATE 1-30-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00830

851

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Virginia

b. COUNTY

Augusta

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b

15 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Stuarts Draft

d. STREET ADDRESS

No street address

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
Gordon
Middle
McMillianLast
Hunter4. DATE
OF
DEATH
January 1,
Month
Year
1957

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

October 31, 1892

9. AGE (In years
lost birthday)
64 yrs.
IF UNDER 1 YEAR: Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John B. Hunter

14. MOTHER'S MAIDEN NAME

Annie V. Ott

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

278-10-2168

17. INFORMANT the Medical Record Address

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Infarction of heart & lungs

INTERVAL BETWEEN
ONSET AND DEATH

1x

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Hodgkin's disease

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office, bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from December 17, 1956, to January 1, 1957, that I last saw the deceased
alive on January 1, 1957, and that death occurred at 9:55 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE*Sherman M. Weissman*

M.D. The Clinical Center

PHYSICIAN'S
NAME (Type)

Sherman M. Weissman, M. D.

National Institutes of Health
Bethesda 14, Maryland

1/1/57

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. LOCATION (City, town, or county)

(State)

*Dec 4 1957**Wayneboro**VA*

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

*J. Wm. Leisius Jr. M.D. ucb DC**Bennie M. Thompson*

BUREAU Y.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00831

Item 18 Film 212 5-27-57 ams

852

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN lb 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park (Patuxent River, Md.)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 710- C M E M Q			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Anne	Middle Wilhelmina	Last HUTTON	4. DATE OF DEATH January 31	Month Day Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 30 Sept. 1922	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY: U.S.	
13. FATHER'S NAME Henry HAUER			14. MOTHER'S MAIDEN NAME Matilda Roman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO WW II	17. INFORMANT (Husband) James Hutton (Same As #2)	Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Wilhelmina, lungia, hyperplasmia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Miliary Tuberculosis</i>			
(b)					
DUE TO (c)		<i>Pulmonary Tuberculosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from 26 Jan. , 19 57 , to 31 Jan. , 19 57 , that I last saw the deceased alive on 30 JAN. , 19 57 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-31-57					
ACTUAL SIGNATURE <i>A. Joseph Cappelletti</i> PHYSICIAN'S NAME (Type) A. Joseph Cappelletti, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 Feb. 1957	22c. NAME OF CEMETERY OR CREMATORIUM Norwood Cemetery	22d. LOCATION (City, town, or county) Norwood, Pennsylvania (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Barnes, Jr.</i>		ADDRESS Deal Funeral Home, 4812 Georgia Ave., Wash.D.C.	24a. REC'D BY REGISTRAR 1-31-57	24b. REGISTRAR'S SIGNATURE <i>Frank L. Russell</i>	

TO PHYSICIAN OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page **1** in by the funeral director, and **2** should be filed with the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please remove carbon papers. This form should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Page **1** may be rejoined by the hospital or attending physician.

Page **2** should be detached prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

BUREAU V. A.

FEB 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6 FilmG21 1 1-7 et

00832

853

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE DISTRICT OF COLUMBIA		CITY COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 3430-39th ST N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Austin Scott Imitie		First	Middle	Last	4. DATE OF DEATH 1 - 19	Month	Day	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-94	9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Adam Scott		14. MOTHER'S MAIDEN NAME Cecilia Daly		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (World War II)		16. SOCIAL SECURITY NO.		17. INFORMANT Audrey (wife)		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibrotic & hyperplastic and fibrotic & chronic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) acute pyelonephritis & acute purulent lymphangitis Carcinoma of Bladder (removed surgically)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis & pulmonary emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 20, 1956 , to June 19, 1957 , that I last saw the deceased alive on June 17, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above.				ADDRESS (Street, City or town, state) M.D. 1801 Eye St. N.W. Wash. D.C. 20530		DATE SIGNED 1/19/57		
ACTUAL SIGNATURE Gordon R. MacDonald								
PHYSICIAN'S NAME (Type) GORDON R. MACDONALD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Va
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th NW Wash. D.C.		24a. REC'D BY REGISTRAR 1-23-57		24b. REGISTRAR'S SIGNATURE Burial in Virginia		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURGESS

MAY 25 1972

KODAK SAFETY FILM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001833

CERTIFICATE OF DEATH

Reg. Dist. No. 223

Item 3 6/21/1 1-3157L

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 1 day 9 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-11		d. STREET ADDRESS 1404 Langley Way	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hospital Washington Sanatorium and				d. STREET ADDRESS 1404 Langley Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle E. Last Elizabeth Jacobsen		4. DATE OF DEATH Month Jan Day 16 Year 1957					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3 1887	
9. AGE (in years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? Amer.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		10c. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Michael O'Connor		14. MOTHER'S MAIDEN NAME Maria Gildea					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumocystis Failure + Deem-a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO lying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12 , 1957, to 1/16 , 1957, that I last saw the deceased alive on 1/16 , 1957, and that death occurred at 11:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 1352 University Lane; Hyattsville, MD	
ACTUAL SIGNATURE Harold Sterling						DATE SIGNED	
PHYSICIAN'S NAME (Type) Harold Sterling							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Grove		22d. LOCATION (City, town, or county) (State) Long Island, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Tammohay		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 1/19/57		24b. REGISTRAR'S SIGNATURE E. Gibson R.D.C.	

BUREAU V.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

789

CERTIFICATE OF DEATH

Reg. Dist. No.

00834
213

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville		25 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Randolph Road	Randolph Road		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
	John	A.	JARBOE
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH	9. AGE (In years last birthday) 73 yrs.
M	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-23-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
U.S. t. Ent. Gov.		List. Col. Gov.	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Eugene E. Jarboe		Mary E. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No --		None	Brother Dr. Eugene D. Jarboe
Address		5211 Conn. Ave. wash D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		central anemia - Buerger's disease 1 week	
Died DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b)		& central vasc. Thrombosis 3 weeks	
} DUE TO		generalized arteriosclerosis 1 day.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		Sept. 1, 1950, to Sept. 1, 1957, that I last saw the deceased alive on _____	
alive on _____		and that death occurred at 4:30 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) Stephen N. Jones, M.D. Rockville, Md. DATE SIGNED 1/4/57	
PHYSICIAN'S NAME (Type)		1/4/57	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORI
Burial		1-5-57	St. Mary's Cath. Ch. Cem. Montgomery
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE
Robert A. Pumphrey		Bethesda Md	1/1/57
		24b. REGISTRAR'S SIGNATURE Laurell Kregtop	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111 V. E

47 1957

GELEV E

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG209 1-21-2 et
775

CERTIFICATE OF DEATH

100835
Reg. Dist. No. 226

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>21 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>802 Thurman Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u>		First <u>Aubrey</u>	Middle <u>Jennings</u>
4. DATE OF DEATH <u>January 11</u>	Month <u>January</u>	Day <u>11</u>	Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH <u>7-9-1907</u>
8. AGE (In years last birthday) <u>49</u>	9. IF UNDER 1 YEAR Months <u>14</u>	10. IF UNDER 24 HRS Hours <u>14</u>	11. IF UNDER 24 HRS Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aubrey Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Chisholm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary C. Clarke R.N. 9107 Flower Ave. Md.</u>		Address <u>Street going</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>Cancer - Pancreas & metastases</u>		19mo -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/22</u> , 19 <u>56</u> , to <u>1/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>57</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ernest A. Sarao M.D.</u> M.D. <u>7006 New Hampshire Ave</u> DATE SIGNED <u>TAKOMA PARK Md</u> <u>1/11/57</u>			
ACTUAL SIGNATURE <u>Ernest A. Sarao M.D.</u>		PHYSICIAN'S NAME (Type) <u>Ernest A. Sarao, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-tran.</u>		22b. DATE THEREOF <u>1/12/1957</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Monticello Mem. Park</u>
22d. LOCATION (City, town, or county) <u>Albemarle Co.</u>		(State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>Date - 12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

DELEAU V. S.

JAN 15 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
212-344-1144
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film 21

Reg. Dist. No. 1100

14826

PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery Bethesda		c. LENGTH OF STAY IN lb 16 hrs.		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Surburban Hospital		d. STREET ADDRESS 6802 Delaware Street		Chevy Chase, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick T		First Middle Last		4. DATE OF DEATH Jan 25 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 17, 1898		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE (State or foreign country) Chicago, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Samuel A		14. MOTHER'S MARRIED NAME Anna Sage Green		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Hosp Records & wife (Dorothy)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease					
42d.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-25-57	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat.	
22d. LOCATION (City, town, or county) Arlington		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Murphy</i>		ADDRESS 7557 Wisc. Av. • 13th, Rd.		24a. REC'D BY REGISTRAR DATE 1-28-57	
				24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the records prior to burial, cremation, or removal.

V5. A15ME(5)
5M 9/55

BUREAU Y.

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001837

776

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Washington Santanum & Hosp. to 1	Wash. D.C. 4411		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
Helene		Maria	Kelle
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-23-82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Karl Schultz	Maria Prehn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Husband - 5002 Arkansas Ave. N.W. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dramamine</u> INTERVAL BETWEEN ONSET AND DEATH <u>5/2 Mo</u>			
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) <u>Digestional Obstruction + Multiple Adhesions</u> 7 Mo			
DUE TO DUE TO <u>Adenocarcinoma of Stomach</u> 17 Mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	4/28/1955		
21. I certify that I attended the deceased from <u>4/28/1955</u> , to <u>1/24/1957</u> , that I last saw the deceased alive on <u>1/24/1957</u> , and that death occurred at <u>1063 Carroll</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1063 Carroll</u> DATE SIGNED <u>1/24/1957</u>			
ACTUAL SIGNATURE <u>Howard J. Morde</u>	PHYSICIAN'S NAME (Type) <u>Howard J. Morde M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-28-1957	22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill	22d. LOCATION (City, town, or county) (State) N. Capital St Wash DC
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rea / Funeral Home 4812 Ga Ave. N.W.</u>	ADDRESS	24a. REC'D BY REGISTRAR DATE <u>28 1957</u>	24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
855 CERTIFICATE OF DEATH

00838

Reg. Dist. No.

216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4, D. C.		d. STREET ADDRESS 2300 Good Hope Road, S. E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elise		First	Middle	Last	4. DATE OF DEATH January 19,	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 5, 1873	9 AGE (In years last birthday) 83	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Hours 0	12 IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missionary		10b. KIND OF BUSINESS OR INDUSTRY Religion		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY/ U.S.A.		
13. FATHER'S NAME Louis Kettler		14. MOTHER'S MAIDEN NAME Elise Knaust						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		<i>Laryngeal Edema</i>				INTERVAL BETWEEN ONSET AND DEATH		
		<i>Moniliasis of Esophagus</i>						
		<i>Chronic Lymphocytic Leukemia</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Waldenström Macroglobulinemia						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington D. C.		(County) D. C. (State) MD
21. I certify that I attended the deceased from December 10, 1956 , to January 19, 1957 , that I last saw the deceased alive on January 19, 1957 , and that death occurred at 7:35 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center								DATE SIGNED 1-20-57
ACTUAL SIGNATURE <i>Arthur J. Garceau</i>		M.D. The Clinical Center						
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D.		National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery		22d. LOCATION (City, town, or county) Washington D. C.		(State) DC
23. FUNERAL DIRECTOR'S SIGNATURE Frank Gevers Sons Co.		ADDRESS 3605-14 St NW		24a. REC'D BY REGISTRAR JAN 23 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson		

BUREAU V. S.

JUN 23 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00839

Reg. Dist. No. 216

856

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John Gardens				c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John Gardens			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Thorne Rd				d. STREET ADDRESS 13 Thorne Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Stanley	Middle Burress	Last Kidwell	4. DATE OF DEATH Jan. 14, 1957		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 37	
9. AGE (In years less birthday) 19 yrs.		10. IF UNDER 1 YEAR Months 10 Days 13 Hours 13 Min		11. IF UNDER 24 HRS Months 10 Days 13 Hours 13 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley A. Kidwell				14. MOTHER'S MAIDEN NAME Virginia Gosnell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-4499		17. INFORMANT Virginia Kidwell (mother) Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) shot gun wound in rt. temple DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted shot gun wound					
20c. TIME OF INJURY Month, Day, Year 12:45 a.m. 1/14 1957		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) Cabin John (County) Montgomery (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) Frank J. Broschart				DATE SIGNED 1/14/57 M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 1-27-57 24b. REGISTRAR'S SIGNATURE <u>Bessie W. Thompson</u>			

TO FEDERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, etc.

TO STATE DIRECTOR: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Boxes 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

VS. ALMSE(S)
SM 9/55

BUREAU V. S

IAN 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00840

857

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>None</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert J. Pumphrey</i>		First <i>Robert</i>	Middle <i>J. P.</i>
4. DATE OF DEATH <i>1/21/57</i>		Month <i>Jan.</i>	Day <i>21</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1/21/37</i>		9. AGE (In years lost birthday) <i>5 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Man in charge of add. office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>	10c. BIRTHPLACE (State or foreign country) <i>Montgomery County</i>
13. FATHER'S NAME <i>John J. Pumphrey</i>		14. MOTHER'S MAIDEN NAME <i>Gandy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	17. INFORMANT <i>John J. Pumphrey</i>
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Julian day Supply Co., Rockville</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>4861 Battery Lane</i>	
21. I certify that I attended the deceased from <i>Jan. 9, 1957</i> to <i>Jan. 17, 1957</i> , that I last saw the deceased alive on <i>Jan. 17, 1957</i> , and that death occurred at <i>4:00 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles J. Savage</i> PHYSICIAN'S NAME (Type) <i>CHARLES J. SAVAGE, M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>4861 Battery Lane</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/21/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn</i>		22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Pumphrey-Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>Date - 21-57</i>	
ADDRESS <i>Robert J. Pumphrey-Bethesda, Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>Beulah M. Thompson</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it may be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with
 the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

858

CERTIFICATE OF DEATH

00841

Reg. Dist. No. 270

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived at time of death)		a. STATE Texas		b. COUNTY Denison	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denison		d. STREET ADDRESS 705 W. Munson Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, 14, Md.									
3. NAME OF DECEASED (Type or print)		First Thelma	Middle <i>Carruth</i>	Last King	4. DATE OF DEATH January 1, 1957	Month January	Day 1	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> January 23, 1902	9. AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or Foreign country) Texas		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Robert Carruth		14. MOTHER'S MAIDEN NAME Ellen Skinner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 466-20-6107		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bleding peptic ulcer</i>						INTERVAL BETWEEN ONSET AND DEATH 36 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)							
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Advanced Rheumatoid Arthritis; Induced hyperadrenal corticism									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from December 31, 1956, to January 1, 1957, that I last saw the deceased alive on January 1, 1957, and that death occurred at 7:50 P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Robert Heaney</i>		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1/2/57			
PHYSICIAN'S NAME (Type) Robert P. Heaney, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/3/57		22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		22d. LOCATION (City, town, or county) Denison, Texas		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2001 14th St. N.W.		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE - 5-5-77		24b. REGISTRAR'S SIGNATURE <i>Janice M. Thompson</i>			

DEAU V.

JAN 8 1957

REFLECTIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

793

CERTIFICATE OF DEATH

00842

213

Reg Dist No

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Montgomery Maryland			a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville		4 Yrs		26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. STREET ADDRESS		
1113 Grandin Ave			1113 Grandin Ave		
			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE OF DEATH	Month Day Year
	Walter	J.	KIRKPATRICK	Jan 2	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-1-1878	79	0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bookbinder		McKibbon & Sons		Pa	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Kirkpatrick Unknown			Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or date of service) --		109-07-3956		Address 1113 Grandin Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) Coronary arteriosclerosis DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) Pulmonary embolism + pneumonia DUE TO					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-27-1957 to 1/2/57, that I last saw the deceased alive on 1/2/57, and that death occurred at 6:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Stephen N. Jones M.D. Rockville, Md. DATE SIGNED 1/2/57 PHYSICIAN'S NAME (Type) Stephen N. Jones Rockville, Md. 1/2/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1957		22c. NAME OF CEMETERY OR CREMATORIAL Parklawn	
22d. LOCATION (City, town, or county) Montgomery Md		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			24a. REC'D BY REGISTRAR DATE NY 1957 24b. REGISTRAR'S SIGNATURE Lowell Kington		

D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

UREAU V. S.

JANUARY 7 1957

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

859

CERTIFICATE OF DEATH

00843

Reg. Dist. No.

17

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS 1212 22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Clifton	Middle Eugene	Last Kosh	4. DATE OF DEATH	Month January	Day 8	Year 19 57

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/31/56	9. AGE (In years from birth) yrs 7	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS Days 8	12. Hours 0	13. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME Kathleen Elizabeth Kosh	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acidosis and Dehydration		INTERVAL BETWEEN ONSET AND DEATH 72 hours
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Gastro-enteritis, Acute		72 hours
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20c. TIME OF INJURY Hour o. s. p. m. 19	Month January	Day 7	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Clarksville, Md.	(County) Howard Co., Md.	(State) Md.
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21. I certify that I attended the deceased from January 7, 1957 , to January 8, 1957 , that I last saw the deceased alive on January 8, 1957 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles S. Whitaker, M.D.								
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ACTUAL SIGNATURE Charles S. Whitaker, M.D.	DATE SIGNED 1/9/57
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.	CLARKSVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-11-57	22c. NAME OF CEMETERY OR CREMATORIUM HOPKINS CHAPEL	22d. LOCATION (City, town, or county) HIGHWOOD, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. CHALMERS GOTHOM, ELICOTT CITY, MD.	ADDRESS 111 N. 155	24a. REC'D BY REGISTRAR 111 N. 155	24b. REGISTRAR'S SIGNATURE Verlaide Lawley
DATE		DATE	

BURDAU V. S.

JAN 14 1957

REGISTRATION
[REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

777

CERTIFICATE OF DEATH

111844
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN TB <i>13 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>1901 East West Highway</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Extravision Hospital</i>				d. STREET ADDRESS <i>1901 East West Highway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Ellsworth</i>	Last <i>Kramer</i>	4. DATE OF DEATH Monthly <i>1</i>	Day <i>23</i>	Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-88</i>	9. AGE (In years last birthday) <i>68 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>			
13. FATHER'S NAME <i>George Kramer</i>		14. MOTHER'S MAIDEN NAME <i>Mirria Prester</i>				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>577-05-7752</i>		17. INFORMANT <i>Chart</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Gen Arteriosclerosis + Hypertension</i> (c) <i>Intestinal Obstr (Tumor Mass - Sigmoid)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Colostomy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1/13/57</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/30</i> , 19 <i>47</i> , to <i>1/23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/23</i> , 19 <i>57</i> , and that death occurred at <i>12th</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard T. Morse M.D.</i>		ADDRESS (Street, city or town, state) <i>703 Carroll Ave</i>		DATE SIGNED <i>1/23/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 26, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George's County, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey</i>		ADDRESS <i>8434 Georgia Ave S.S.</i>		24a. REC'D BY REGISTRAR DATE <i>1-25-57</i>		24b. REGISTRAR'S SIGNATURE <i>F. Johnson R. 201A</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.
RECEIVED

JAN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00845

860

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6666 Hillandale Road		d. STREET ADDRESS 6666 Hillandale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ROSCOE	Middle Graham	Last Lamb	4. DATE OF DEATH 11	Month January	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/97		9. AGE (in years from birthdate) 59 yrs.	10. IF UNDER 1 YEAR Months 11 Days 18 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Own		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Roscoe G. Lamb, Sr.		14. MOTHER'S MAIDEN NAME Annie Weller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. I		17. INFORMANT Anne P. Lamb		Address 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Carcinoma of pancreas (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary atherosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Oct 26, 1956, to Jan 31, 1957.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 26, 1956 , to Jan 31, 1957 , that I last saw the deceased alive on Jan 30, 1957 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4711 Highland Ave., Beth., Md.							
DATE SIGNED 1/31/57							
ACTUAL SIGNATURE Alfred S. Norton M.D.							
PHYSICIAN'S NAME (Type) Alfred S. Norton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Blayney		ADDRESS 7557 Wisc. Ave Beth		24a. REC'D BY REGISTRAR Bessie M. Thompson		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	
VS A15 (4) 15M 9/55		DATE 1/31/57					

BUREAU V. S

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 filr 101-257 et

00846
Reg. Dist. No. 217

861

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oney		c. LENGTH OF STAY IN 1b 9 days-		b. COUNTY Holmes	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION Brooke Grove Chronic Hosp-				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) Elo		First E	Middle l	(Last) wanson	4. DATE OF DEATH Jan. 15 1957
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1874	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife -		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Colt Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas O. Fitzpatrick		14. MOTHER'S MAIDEN NAME Sarah Eldridge -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO		17. INFORMANT Mrs Chas. M. Jackson - 501 chillium Rd Hyattsville Md -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Cochlea + labyrinth + d. tabes		INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c)		ca of abdominal Cancer Gen. 3 eyes - Gen. Metastases + Diaphysis			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15 , 1957, to Jan. 15 , 1957, that I last saw the deceased alive on Jan. 15 , 1957, and that death occurred at Oney, Md. M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) John B. Ziegler, M.D. DATE SIGNED Jan. 15, 1957	
22a. MEDICAL CERTIFICATION ACTUAL SIGNATURE John B. Ziegler		22b. PHYSICIAN'S NAME (Type) John B. Ziegler			
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. DATE THEREOF 1-18-57		22e. LOCATION (City, town, or county) Windfall Indiana (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon Barber, Taylorsville, Md.		ADDRESS Taylorville, Md.		24a. REC'D BY REGISTRAR DATE 1-18-57	
				24b. REGISTRAR'S SIGNATURE Estherde B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

862

CERTIFICATE OF DEATH

00847

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meade Heights, Ft. Meade	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1905 E Resse Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sylvia	Middle (no middle name)	Last Lapiner	4. DATE OF DEATH January 7, 1957	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1919	9. AGE (In years last birthday) 37 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Harry Kosofsky		14. MOTHER'S MAIDEN NAME Etta Kutler		12. CITIZEN OF WHAT COUNTRY/ U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>acute lymphatic leukemia</i> DUE TO (c) <i>gram negative septicemia</i> <i>and lympho pulmonary emboli</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 19, 1956 , to January 7, 1957 , that I last saw the deceased alive on January 7, 1957 , and that death occurred at 10:00AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED			
ACTUAL SIGNATURE <i>D.G. Nathan, M.D.</i>		M.D.			
PHYSICIAN'S (NAME TYPE) D.G. Nathan, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/57		22c. NAME OF CEMETERY OR CREMATORIUM Knollwood Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N. W.		ADDRESS Wash., D. C. 14th St., N. W.		24a. REC'D BY REGISTRAR DATE -10-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00848

863

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Rt. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BARRY	Middle BOY	Last Lawhorne	4. DATE OF DEATH January 14	Month 1957	Day 14	Year 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/57	9. AGE (In years lost birthday) yrs. 0	IF UNDER 1 YEAR: IF UNDER 24 HRS Months 4 Days 10 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Edward Lawhorne				14. MOTHER'S MAIDEN NAME Helen Melean Floyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Mother		Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral atelectasis of lung INTERVAL BETWEEN ONSET AND DEATH 3 hours							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Damascus	(County) Maryland	(State)	
21. I certify that I attended the deceased from 1/14 , 19 56 , to 1/14 , 19 56 , that I last saw the deceased alive on 1/14 , 19 56 , and that death occurred at 6:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 1/18/57			
PHYSICIAN'S NAME (Type)		M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 1 Jan. 15, 1957		22b. DATE THEREOF 1 Jan. 15, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Saylerville		22d. LOCATION (City, town, or county) Saylerville Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Barber Saylerville Md.		ADDRESS 7344xx		24a. REC'D BY REGISTRAR DATE 1-18-57		24b. REGISTRAR'S SIGNATURE Serinda B. Lawler	

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00849

Reg. Dist. No. 8:6

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 Days		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE D.C.		b. COUNTY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
						d. STREET ADDRESS 5223 4th Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Henry	Middle -	Lost Leish	4. DATE OF DEATH January 26	Month January	Day 26	Year 1957	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1906		9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Leish				14. MOTHER'S MAIDEN NAME Dora Rubin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				ACUTE LEUKEMIA		ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) OBESITY				BRONCHO-PNEUMONIA		ACUTE MYELOGENOUS LEUKEMIA		1 WKS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)					
21. I certify that I attended the deceased from January 24, 1957 , to January 26, 1957 , that I last saw the deceased alive on January 26, 1957 , and that death occurred at 5:15A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Bethesda 14, Maryland									
DATE SIGNED 1/26/57									
ACTUAL SIGNATURE Gurston Goldin		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland							
PHYSICIAN'S NAME (Type) GURSTON GOLDIN, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Casket		22b. DATE THEREOF 1/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Geo. Wash. Mem. Cem. Hyattsville Md.		22d. LOCATION (City, town or county) Hyattsville Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		ADDRESS 4217-9 Rue		24a. REC'D BY REGISTRAR Date 28-01		24b. REGISTRAR'S SIGNATURE Reenie M. Linton			
VS A15 (4) 15M 9/55									

RECEIVED
BUREAU V.

JAN 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

865

CERTIFICATE OF DEATH

Reg. Dist. No. 215

011850

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Virginia		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 6712 Glen Carlyn Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Gordon	Last LETCHWORTH	4. DATE OF DEATH	Month January	Day 14	Year 1957				
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1897	9. AGE (in years last birthday) 59	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Appraiser		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Thomas Letchworth								14. MOTHER'S MAIDEN NAME Blanch Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Wife) Mrs. Adelia M. Letchworth (Same As #2)		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral, due to 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Atherosclerosis, Middle Cerebral Artery DUE TO DUE TO (c) approx 24 hrs approx. 10 years								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I attended the deceased from 22 November, 1956 , to 14 Jan., 1957 , that I last saw the deceased alive on 14 Jan., 1957 , and that death occurred at 6:24 P. M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>R. G. Williams</i>	M.D. U.S. Naval Hospital, Bethesda, Md. 1-15-57										
PHYSICIAN'S NAME (Type) R. G. WILLIAMS, CDR, MC, USN	U.S. Naval Hospital, Bethesda, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-18-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ives Funeral Home</i>		ADDRESS Virginia 2847 Wilson Blvd. Arlington,		24a. REC'D BY REGISTRAR Tracy E. Passelly		24b. REGISTRAR'S SIGNATURE <i>Tracy E. Passelly</i>					
VS A15 (4) 15M 9/55				DATE 1-15-57							

BUREAU NO 6

JAN 13

REG'D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(11)851

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San and Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Harry	Middle E.	Last Liles				
4. DATE OF DEATH	Month Jan	Day 10, 1957	Year 19				
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/64				
9. AGE (in years from birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer - FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY WALTER REED					
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph B. Liles		14. MOTHER'S MAIDEN NAME Nettie D. Stripling					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES					
17. INFORMANT William C. SPROESSER		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion							
L Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 10, 1957			
NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JAN. 14, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln	
23. FUNERAL DIRECTOR'S SIGNATURE WW Chambers Co. Wash DC.		ADDRESS 517-17 30th SE		24a. REC'D BY REGISTRAR 1/11/57		24b. REGISTRAR'S SIGNATURE John H. Hildreth	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and hour of issue. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form 11M3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

BUREAU V.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001852

866

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 9914 Thornwood Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Theresa	Middle Augusta	Last LIND	4. DATE OF DEATH	Month January	Day 12	Year 19 457	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1888	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY/ (Naturalized) U.S. (Naturalized) U.S.		
13. FATHER'S NAME Anders Anderson		14. MOTHER'S MAIDEN NAME Augusta Johansson		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son-In-Law) Lewis J. Reber (Same As #2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Advanced Carcinoma of the Stomach with Metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastasis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH <i>approx. 1 year</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>U.S. Naval Hospital, Bethesda, Md.</i> (County) <i>Montgomery</i> (State) <i>Md.</i>		
21. I certify that I attended the deceased from 12-8- 19 56 to 1-12-57 , 19 57 , that I last saw the deceased alive on 1-11- 1957 , and that death occurred at 0115A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-12-57								
ACTUAL SIGNATURE <i>Ronald P. Dobbie</i>								
PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-57		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville Pike, Rockville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR Bray, E. Farrelly		24b. REGISTRAR'S SIGNATURE <i>Bray, E. Farrelly</i>		
DATE 1-12-57								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Bureau X. S.

JAN 14 1957

RECEIVED
FBI - LOS ANGELES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

779 CERTIFICATE OF DEATH

Reg. Dist. No. **223**

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>Richard Lovick</i>		d. STREET ADDRESS <i>820 Thayer Ave</i>	
First Richard Middle Lovick Last Lockett		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 19 - 1888</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>68 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Lockett</i>		14. MOTHER'S MAIDEN NAME <i>Maeay Geddon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>578-01-7842</i>	
17. INFORMANT <i>Digital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure.</i> DUE TO <i>H2O.</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic congestive heart failure.</i> DUE TO <i>CHF.</i> (c) <i>Arterio-sclerotic heart disease.</i> DUE TO <i>CHF.</i> 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7701 Carroll Ave</i>	
20f. (City or town) <i>Takoma Park, Md.</i>		(County) <i>Montgomery County</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Oct. 1956</i> to <i>Jan. 2, 1957</i> that I last saw the deceased alive on <i>January 2, 1957</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James M. Whitlock</i>		ADDRESS (Street, city or town, state) <i>7701 Carroll Ave</i>	
PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>		DATE SIGNED <i>1-3-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/5/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Lumpbrey</i>		ADDRESS <i>8434 Takoma Silver Spring</i>	
24a. REC'D BY REGISTRAR <i>1/7/57</i>		24b. REGISTRAR'S SIGNATURE <i>William Dodd</i>	

BUREAU

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
867 CERTIFICATE OF DEATH

(111854)

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 150 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-15-2		d. STREET ADDRESS 5710 - 16th Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Pamela		First Pamela	Middle -	Last Manchester	4. DATE OF DEATH January 24	Month January	Day 24	Year 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1955	9. AGE (In years last birthday) 1 yrs	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John E. Manchester		14. MOTHER'S MAIDEN NAME Pearl Johnson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754 14 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Acute Anoxia		INTERVAL BETWEEN ONSET AND DEATH					
(b) DUE TO Cerebral thromboses									
(c) Congenital Heart Disease, Transposition of great vessels									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dolly cestrumca						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from August 27, 1956 , to January 24, 1957 , that I last saw the deceased alive on January 24, 1957 , and that death occurred at 3 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Theodore Cooper, M.D. DATE SIGNED 1/24/57									
ACTUAL SIGNATURE Theodore Cooper, M.D.		PHYSICIAN'S NAME (Type) Theodore Cooper, M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/28/57		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Clarke G. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1-28-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAN 30, 1957

REGELIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00855

780

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

J. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Montgomery MARYLAND		Md. Montg				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Tahoma Park	3 months	Silver Spring				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cedar Haven 7300 T. Ballmer Ave. Rest Home	200 W Franklin					
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
Jean White	Ella	Marquis	4. DATE OF DEATH			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
			Jan 19 1871	86		
14. USUAL OCCUPATION (Give kind of work done for kind of business or industry during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife - Own Home		West Virginia		U.S.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Thomas Jefferson Headley		Elvera Pride				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address		
NO		My C.C. Brown 350 Madison Pl Hgtnville Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
DUE TO Cerebral Thrombosis						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO Pneumonia left base						
DUE TO Cerebral Thrombosis						
INTERVAL BETWEEN ONSET AND DEATH 1/26/56						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 3/55, 19, to Jan 28, 1957, that I last saw the deceased alive on Jan 28, 1957, and that death occurred at 6:25 A.M. from the causes and on the date stated above.						
ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE Howard Morse M.D. ADDRESS (Street, city or town, state) DATE SIGNED 1/28/57						
PHYSICIAN'S NAME (Type) Howard T Morse Tahoma Park Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 1/30/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)
				Bethel Cemetery		Parkersburg, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
Constance C. Humphrey		Silver Spring, Md.		DATE 1-30-57		J. Helen Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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00856

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

791

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN lb 6½ yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 BEVERLY ROAD, Manor Club		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
f. STREET ADDRESS 101 BEVERLY ROAD, Manor Club		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SALLIE	Middle L.	Last MARSHALL
4. DATE OF DEATH	Month JANUARY	Day 4	Year 19 57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 2, 1873
9. AGE 83 (last birthday) yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (Retired)		10b. KIND OF BUSINESS OR INDUSTRY TREASURY DEPT. U. S. GOVERNMENT	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SILAS B. BROADDUS		14. MOTHER'S MAIDEN NAME SARAH GOLDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mr. Andrew B. Marshall, 101 Beverly Rd.	Address Manor Club, Rockville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral decomp. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (d) Found dead in bed INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-4-57
EXAMINER'S NAME (Type) FRANK J. BROSCHEART	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/7/57	22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Lumprey,</i>	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR 1/7/56	24b. REGISTRAR'S SIGNATURE <i>Laurell Gregor</i> <i>Per E.C.</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film 210 2-4-57 ams

CERTIFICATE OF DEATH

00857
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 512 Woodston Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Tanita		First	Middle	Last	4. DATE OF DEATH MARTIN	Month	Doy	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 13 Nov. 1880	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Puerto Rico		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Ceferino Fernandez			14. MOTHER'S MAIDEN NAME Emelia Santiago						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Daughter) Jeanne A. Layne, (Same As #2)			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bacterium meningitidis</i>									INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Escherichia coli</i>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia		
21. I certify that I attended the deceased from 21 Jan. , 19 57 , to 24 Jan. , 19 57 , that I last saw the deceased alive on 24 Jan. , 19 57 , and that death occurred at 09:15 AM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state)
									DATE SIGNED
ACTUAL SIGNATURE <i>A. Joseph Cappelletti</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 1-24-57							
PHYSICIAN'S NAME (Type) A. Joseph Cappelletti, LCDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington			(State) Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. E. Pumphrey</i>		ADDRESS 1551 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-24-57		24b. REGISTRAR'S SIGNATURE <i>Joseph E. Cassell</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

001858

Reg. Dist. No. 516

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		b. COUNTY <i>Washington 412</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>6353 - 31ST Place N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>HERMAN</i>	Middle <i>A</i>	Last <i>MATSON</i>	4. DATE OF DEATH Month <i>1 - 26</i>	Day Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-6-92</i>	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>Washington STATE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Wardwell</i>		17. INFORMANT <i>Robert (Son) 6353 - 31ST Place N.W.</i>		Address <i>Wash., D.C.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Thrombosis</i>		DUE TO <i>Coronary Artery Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
(b) DUE TO <i>Coronary Artery Sclerosis</i>		(c)		<i>2 years</i>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month <i>July</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>55-6 Rebdarex, 1-26-57</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>Jan 26</i> , 1957, that I last saw the deceased alive on <i>Jan 25</i> , 1957, and that death occurred at <i>9:35 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert B. Harrell</i>						ADDRESS (Street, city or town, state) <i>55-6 Rebdarex, 1-26-57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/30/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>	22d. LOCATION (City, town, or county) <i>Arlington</i>		(State) <i>Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave., Bethesda, Md.</i>	24a. REC'D BY REGISTRAR <i>Pearlie M. Thompson</i>		24b. REGISTRAR'S SIGNATURE <i>Pearlie M. Thompson</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

870

CERTIFICATE OF DEATH

00859

Reg. Dist. No. 217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 30 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS 12412		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Clinton Mauck		First	Middle	Last	4. DATE OF DEATH January 26 1957	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/05		9. AGE (In years lost birthday) 51 yrs.	10. IF UNDER 1 YEAR; IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Helper		10b. KIND OF BUSINESS OR INDUSTRY FARM.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Mauck		14. MOTHER'S MAIDEN NAME Lora Lee Kline							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Hospital Record									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Nstitution DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Tension Myocarditis with DUE TO (c) Hypertension 8 years INTERVAL BETWEEN ONSET AND DEATH 20 min									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) C							
20c. TIME OF INJURY Hour o. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 10/11 , 19 57 , to 1/26/57 , 19 57 , that I last saw the deceased alive on 1/23/57 , 19 57 , and that death occurred at 3:00 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE J. H. Bird									
ATTENDANT'S NAME (Type) J. H. Bird, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 28, 1957		22b. DATE THEREOF Jan 28, 1957		22c. NAME OF CEMETERY OR CREMATORIAL St Paul Cemetery		22d. LOCATION (City, town, or county) Fulton Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Geraldine Sawyer		ADDRESS 7100		24a. REC'D BY REGISTRAR DATE 1-29-57		24b. REGISTRAR'S SIGNATURE Geraldine Sawyer			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

101860
Reg. Dist. No. 215.

1. PLACE OF DEATH a. COUNTY		871	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery		MARYLAND	a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda (Rural)		7 days	Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
U.S. Naval Hospital, Bethesda, Md.		3609 Prospect		
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print)	First Jeremiah	Middle (nm)	Last MC CARTHY	4. DATE OF DEATH January 22 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 17 Oct. 1870	9. AGE (In years last birthday) 86 95 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Dist. Gov't		10c. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME John Mc Carthy		14. MOTHER'S MAIDEN NAME Mary Daly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Sp.Am.War	17. INFORMANT Unknown	Address Official Navy Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH Sudden				
903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of left Hip</u> 10 days				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on Rug at Home and fractured left hip		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1-12- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Washington, D. C.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	Frank J. Broschart			DATE SIGNED 1-22-57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-25-57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins	ADDRESS Francis J. Collins Funeral Home, Washington, D.C.	24a. REC'D BY REGISTRAR DATE 1-22-57	24b. REGISTRAR'S SIGNATURE Dorothy L. Russell	

PUT MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the examiner or files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the remains or prior to burial, removal.

DEPARTMENT OF STATE

1937

REVIEWED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00861

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY	MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 CHEVY CHASE		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 141-GRAFTON ST.				d. STREET ADDRESS		141- GRAFTON ST.				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
MARY		S.	McDONALD		JAN	22	1957			
5. SEX	F	6. COLOR OR RACE	W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
				3-11-1877	79 yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William STELLER		14. MOTHER'S MAIDEN NAME ELIZABETH BUTZERINE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wm. Hack-141- GRAFTON St. C.C. Ho.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory & Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Cerebral vascular accident		2 YRS.						
(b) DUE TO		Antemiosclerosis & Anteisclerotic heart disease.		20 YRS.						
(c)										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
19										
21. I certify that I attended the deceased from July 21, 1955 to Present, that I last saw the deceased alive on January 21, 1957, and that death occurred at 3:30A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE Donald W. Skeman				DATE SIGNED M.D. 2707 Wisconsin Ave, Chevy Chase Md.						
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, Town or county)		(State)		
1-25-57		Mt. Olivet Cemetery		Washington DC						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE				
Timothy Hanlon 3831 Falmo Rd.				JAN 23 1957		Jessie Thompson				
VS A15 (4) 15M 9/55										

TRÉAU Y.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

781

CERTIFICATE OF DEATH

(111862)

Reg. Dist. No.

✓713

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 21 days	
<i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>3432 Floral St</i>	
<i>washington San + Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>Lou</i>
4. DATE OF DEATH		Month <i>January</i>	Day <i>8</i>
5. SEX		6. COLOR OR RACE <i>Female</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9/18/1878</i>		9. AGE (In years lost birthday) <i>78 yrs</i>	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Martin O'Brien</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Owens</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Hosp Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		b. infant, left parietal lobe, cerebrum INTERVAL BETWEEN ONSET AND DEATH <i>10 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Multile healing pancreatic fat necroses.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/17</i> , 19 <i>56</i> , to <i>1/8/17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/8/17</i> , 19 <i>57</i> , and that death occurred at <i>1/8/17</i> , 19 <i>57</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. W. L. Hobin</i> PHYSICIAN'S NAME (Type) <i>Dr. H. W. L. Hobin</i>		ADDRESS (Street, city or town, state) <i>500 Underwood St. N.W., Wash. D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/10/57</i>	
22c. NAME OF CEMETERY <i>RONCEVERTE</i>		22d. LOCATION (City, town, or county) <i>RONCEVERTE, W.Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Chambers Co</i>		24a. REC'D BY REGISTRAR DATE <i>Jan 11 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Davis</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Page 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X's

JAN 11 1968

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

782 CERTIFICATE OF DEATH

00863
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 mos. 8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		d. STREET ADDRESS <i>7537 Carroll Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Virginia</i>	Middle <i>Belle</i>	Last <i>Mellen</i>	4. DATE OF DEATH	Month <i>January</i>	Day <i>25</i>	Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-15-72</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>John Fisher</i>			14. MOTHER'S MAIDEN NAME <i>Martha Lippincott</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sympathetic Leukemia</i> 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>6911 5th St. N.W.</i>	(County) <i>Washington, D.C.</i>	(State) <i>D.C.</i>				
21. I certify that I attended the deceased from <i>Jan. 2, 1956</i> to <i>Jan. 25, 1957</i> , that I last saw the deceased alive on <i>Jan 25, 1957</i> , and that death occurred at <i>1213 N. L.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>O.B. Little</i>	ADDRESS (Street, city or town, state) <i>Washington, D.C.</i>		DATE SIGNED <i>1/28/57</i>						
PHYSICIAN'S NAME (Type) <i>A. B. LITTLE</i>									
22a. BURIAL, CREMATION, REMAINS (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/28/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>	22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>	(State) <i>D.C.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wilson Doherty</i>	ADDRESS <i>1011 New Hampshire Avenue, N.W.</i>	24a. REC'D BY REGISTRAR <i>J. Wilson Doherty</i>	24b. REGISTRAR'S SIGNATURE						

HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Forms 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. L.

IAN 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00864

873

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3807 Quincy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Leo	Last Merkle	4. DATE OF DEATH Month January	Day 16,	Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1887	9. AGE (In years lost birthday) 69 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph A. Merkle			14. MOTHER'S MAIDEN NAME Louise Seaman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-10-1893		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cirr., shock DUE TO 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Gastric or intestinal bleeding = d.p. DUE TO (c) acute myocardial infarction 1 year. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizm. in Cirrosis						INTERVAL BETWEEN ONSET AND DEATH 6 hours.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center		20f. (City or town) Bethesda 14, Maryland		(County)	(State)
21. I certify that I attended the deceased from January 7, 1957 , to January 16, 19 57 , that I last saw the deceased alive on January 16, 19 57 , and that death occurred at 7:07 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland									
ACTUAL SIGNATURE David G. Nathan		M.D.		DATE SIGNED 1/17/57					
PHYSICIAN'S NAME (Type) David G. Nathan, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Casket		22b. DATE THEREOF 1-21-57		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery, Silver Spring, Md.		22d. LOCATION (City, town, or county) Silver Spring, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home		ADDRESS 3200-R. I Ave. Mt. Rainier, Md.		24a. REC'D. BY REGISTRAR 1-23-57		24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEBRUARY 1957

JAN 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00865
274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN lb 5½ yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12014 Valley Wood Drive		d. STREET ADDRESS 12014 Valley Wood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLIAN MARTIN (ELIZABETH) MIDDLETON	First	Middle	Last
4. DATE OF DEATH	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26th, 1869
9. AGE (in years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
10c. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Marvel		14. MOTHER'S MAIDEN NAME Harriett Fink	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT William B. Middleton, 12014 Valley Wood Dr		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO CarCinoma Liver Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO CarCinoma Colon (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Robert R. Hottel, M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Fernwood Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR JAN 28 1957	
		24b. REGISTRAR'S SIGNATURE Lances Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the remains prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

875 CERTIFICATE OF DEATH

Reg. Dist. No. 018664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery		Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town).		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring		12 yrs		Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8808 Reading Rd.		8808 Reading Rd			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	DATE OF DEATH
Michael			—	Milkie	Jan 20, 1957
4. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH	8. AGE (In years from birth) yrs.
Male		White		May 1, 1896	60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Accountant		Bakery		Lebanon	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Abraham Milkie		Alexandria Mafrige		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or No answer) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Gabriel Milkie	
Address		8808 Reading Rd		SILVER SPRING MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
		faul		8 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		CORONARY Occlusion	
		DUE TO		CORONARY ATHEROSCLEROSIS	
		(c)		10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from		Oct. 1956, to Jan. 20, 1957		that I last saw the deceased alive on 20 Jan 1957, and that death occurred at 5N. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		L.B. Snow		ADDRESS (Street, city or town, state) 901 1/2 Florida Ave, Silver Spring, Md.	
PHYSICIAN'S NAME (Type)				DATE SIGNED 20 Jan. 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI	
Burial 1/23/57		Glenwood		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
W.W. Chambers Co		1400 Chapin St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE	
				Frances Pellerin Jan 23 1957	

BUREAU V. S

IAN 32 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111867

Reg. Dist. No. 216

CERTIFICATE OF DEATH

876

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town	
Bethesda 2 1/2 weeks		Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Suburban Hospital		Box 158	
3. NAME OF DECEASED (Type or print)		First	Middle
Estelle White		Miller	Last
4. DATE OF DEATH		Month	Day
		Jan. 30	1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female			
8. DATE OF BIRTH		9. AGE (In years at birthday) yrs.	
Dec. 24, 1891		10	10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Decorates Interior decorations		Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Highth Jones		Margaret N. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		Address Box 158 Kensington Md	
No			
16. SOCIAL SECURITY NO.		17. INFORMANT	
503-14-6084		Mrs. Margaret N. Davis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 week to 6 mos	
420.0		Pneumonia & Cerebral Embolism	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Congestive Heart Failure	
(b)		3 mos	
DUE TO			
(c)		Paroxysmal arterio-occlusive hyperensive disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 26, 1956</u> , to <u>Jan 30, 1957</u> , that I last saw the deceased alive on <u>Jan 30, 1957</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>George Sharpe</u> MEDICAL NAME (Type) <u>George Sharpe M.D.</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> DATE SIGNED <u>1/31/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
22d. LOCATION (City, town, or county) (State)		Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>1-31-57</u>	
<u>Robert A. Murphy</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

MAY be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Ans
RECEIVED
FEB 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

111868

Reg. Dist. No.

74

877

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		Md. <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town)	
<i>Silver Spring</i>	6 mths	<i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>8825 Glenville Rd.</i>	<i>8825 Glenville Rd.</i>		
3. NAME OF (Type or print)	First	Middle	Last
	KATHERINE	MARIE	MILLER
4. DATE OF DEATH	Month	Day	Year
	JAN.	4	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>March 16, 1885</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
77	1 yrs.	1 months	1 min.
10a. USUAL OCCUPATION (Give kind of work done) during/most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Homemaker</i>	<i>At Home</i>	<i>England</i>	<i>U. S. A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
? <i>Pollard</i>	<i>Nal known</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)	<i>none</i>	<i>Oscar R. Miller, 8825 Glenville Rd. 8825</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Terminal	
410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PULMONARY EDEMA	
(b)		Rheumatic heart Disease, Mitral Insufficiency	
DUE TO (c)		Congestive failure	
		Many yrs 2-3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Marked Emaciation			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a. m. p. m.	19	White at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1954, to _____, 1953, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, M, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
<i>Chas H. W. Lohman</i>		M.D.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
<i>Chas H. W. Lohman</i>		1/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 7, 1957	National Memorial Park	Gales Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>J. Arthur Waters</i>	254 Carroll St N.W. LLC	DATE, N 7 1957	<i>Frances Potters</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. V. 111

JAN 7 1957

EGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

878

CERTIFICATE OF DEATH

00869

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 YRS	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HORTENSE CONTEE MIXSELL		First	Middle
4. DATE OF DEATH JAN 8 1957		Last	Month
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH NOV 6, 1876		9. AGE (In years less birthday) 80 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Contee		14. MOTHER'S MAIDEN NAME Elizabeth Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-03-9008B	
17. INFORMANT Mrs. E. A. Ginnetti-Same Item #2 - daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 495X		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 2 1957 to JAN 8 1957 , that I last saw the deceased alive on JAN 7 1957 , and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 703 FARRAGUT MEDICAL BLDG 900-17TH ST N.W. WASHINGTON D.C. DATE SIGNED 1-8-57			
ACTUAL SIGNATURE Lewis H. Biben		M.D.	
PHYSICIAN'S NAME (Type) LEWIS H. BIBEN			
22a. BURIAL, CREMATION, or other (Specify) Burial		22b. DATE THEREOF 1/10/1957	
22c. NAME OF CEMETERY OR CREMATORIALy Mt. Olivet		22d. LOCATION (City, town, or county) Washington (State) Dist. Columbia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DATE -8-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00870

879 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 195 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 7106 Arrowwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marshall	Middle Henry	Last Montrose, Jr.	4. DATE OF DEATH January 24th, 1957	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 24th, 1913	9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Navy Dept., Wash.D.C.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall H. Montrose			14. MOTHER'S MAIDEN NAME Zoe Maltby				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. #2		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Healed tuberculosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)
21. I certify that I attended the deceased from July 13th, 1956 , to January 24th 1957 , that I last saw the deceased alive on January 24th, 1957 , and that death occurred at 10:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/24/57 ACTUAL SIGNATURE John Laszlo PHYSICIAN'S NAME (Type) John Laszlo, M. D. M.D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/20/57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Int.	22d. LOCATION (City, town, or county) Arlington (State) Va.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey	ADDRESS 7557 N.W. 14th Street	24a. REC'D BY REGISTRAR Beasie M. Thompson	24b. REGISTRAR'S SIGNATURE Date (1-28-57)				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED
BUREAU V

JAN 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001871

889

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 115 No. Abingdon Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle Aileen	Last Moore	4. DATE OF DEATH January 8, 1957	Month Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 10, 1908	9. AGE (In years lost/birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) District of Columbia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John E. Scheckells		14. MOTHER'S MAIDEN NAME Blanche Haney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-03-0615		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO		Shock, cerebral metastatic carcinoma to liver, lungs, pleura, lymph nodes & pleural effusion - 5 yrs Primary carcinoma left Breast 11 yrs?					
DUE TO							
(b)							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 28, 1956, to January 8, 1957, that I last saw the deceased alive on January 8, 1957, and that death occurred at 1:40 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/8/57					
ACTUAL SIGNATURE Donald E. Kayhoe		M.D.					
PHYSICIAN'S NAME (Type) DONALD E. KAYHOE, M. D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company, Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR 10-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.
REGHIVED

JAN 14 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

881

CERTIFICATE OF DEATH

10872

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE						
Montgomery MARYLAND		Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 15 yrs						
Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 24 Brooks Ave						
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF (Type or print)		First Mary	Middle M					
4. DATE OF DEATH		Month Jan	Day 17					
		Year 1957						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at last birthday): 70 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
Female		White		May 23-1888				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife		Home		Lutherville		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Nathan Cooke		Harriet Waters						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes, give war or dates of service)				Virginia Bell		Montgomery Co., Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Cardiac Failure			1½ days			
X		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) dehydration			4 days			
		(c) debility			5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
19								
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE		Frank J. Broschart		M.D.		DATE SIGNED 1/17/57		
PHYSICIAN'S NAME (Type)		Frank J. Broschart						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		
Burial		1-19-57		Goshen		Lutherville, Mont. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Ernest C. Gartner		Katherineburg		Date Jan 19-57		Abner G. Cooke		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU A. S.

REGISTRATION
KELGEI VEG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

001873

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 7 hrs.		d. STATE Maryland b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Damascus) RFD Monrovia X-2		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) EDGAR Maynard MOXLEY		First	Middle	Last	4. DATE OF DEATH January 22 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1907	9. AGE (in years from birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant, gas station		10b. KIND OF BUSINESS OR INDUSTRY Service station		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Cornelius P. Moxley		14. MOTHER'S MAIDEN NAME Florence Poole		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 220-05-6149		17. INFORMANT Address Vernie (brother) Damascus, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 416.0					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO First, second & third degree burns, involving about 60% of body. (c)					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sleeping, when bed caught fire			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12:05-22 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Damascus		(County) Montgomery		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-22-57
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 25, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Montgomery		22d. LOCATION (City, town, or county) Clagettsville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. McLeanworth</i>	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR 1-26-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

BUREAU Y. S.

IAN

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00874

Reg. Dist. No. 211

1 883											
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN 1b life									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Monrovia		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Damascus									
3. NAME OF DECEASED (Type or print) Virgie Irene Moxley		First Virgie	Middle Irene	Last Moxley	4. DATE OF DEATH January 22	Month January	Day 22	Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1900		9. AGE (in years last birthday) 56 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Cornelius Moxley		14. MOTHER'S MAIDEN NAME Florence Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-1440		17. INFORMANT Vernie Moxley, Damascus, Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion		19. INTERVAL BETWEEN ONSET AND DEATH sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4-0-1		(b)		DUE TO		(c)		DUE TO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 22, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Montgomery		22d. LOCATION (City, town, or county) Clagettsville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olm L. Woburn</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR Jan. 25/57		24b. REGISTRAR'S SIGNATURE Laura W. B. Well					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File forms 1 and 2 with the remains prior to burial, cremation, or removal.

BUREAU V. 2

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 the certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

884

CERTIFICATE OF DEATH

00875

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 16		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS 205 DELLA AVE						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ralph		First	Middle	Last	4. DATE OF DEATH January 25 1957	Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/91	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME HAYWARD MULLINEAUX		14. MOTHER'S MAIDEN NAME UNKNOWN										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 212-32-0224		17. INFORMANT Medical Record		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebrovascular accident				INTERVAL BETWEEN ONSET AND DEATH 24 hours						
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Essential hypertension				5 years						
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from 12/14/56 , 19, to 12/20/56 , 19, that I last saw the deceased alive on 1/24/57 , 19, and that death occurred at 12:20 P.M. from the causes and on the date stated above.												
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		M.D.		ADDRESS (Street, city or town, state) Clarksville, Md		DATE SIGNED 1/25/57						
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/57		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>FC Huie</i>		ADDRESS <i>Ellicott City, Md.</i>		24a. REC'D BY REGISTRAR 281		24b. REGISTRAR'S SIGNATURE <i>Gatwick Lander</i>						

BUREAU Y.

IAN 28 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00876

885

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>408 Cushing Drive</i>		e. STREET ADDRESS <i>14908 Cushing Drive</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>RUBY</i>	Middle <i>GOLDEN</i>	Last <i>NAUGHTON</i>
4. DATE OF DEATH	Month <i>Jan</i>	Day <i>27</i>	Year <i>1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 27 1905</i>
9. AGE (In years Not birthday) <i>52 yrs</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
10c. BIRTHPLACE (State or foreign country) <i>Kensington</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>David Franklin Kogey Rice</i>		14. MOTHER'S MAIDEN NAME <i>Bertha B. Rice</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ret'd. or unknown) <i>No</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i></i>	
17. INFORMANT <i>John B. Naughton</i>		Address <i>4908 Cushing Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema (terminal)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hr</i>	
1957 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		DUE TO <i>Hemolytic metastatic carcinomatosis</i>	
DUE TO <i>Cancerous of left ovary</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 mth</i>	
DUE TO <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>7-8 mth</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour <i>a.m.</i> <i>19</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 26</i> , 1957, to <i>Jan 26</i> , 1957, that I last saw the deceased alive on <i>Jan 26</i> , 1957, and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>George H. McLain</i>			
PHYSICIAN'S NAME (Type) <i>Geo. H. McLAIN, M.D.</i>		ADDRESS (Street, city or town, state) <i>1746 K St. N.W.</i>	
		DATE SIGNED <i>Jan 27-1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/31/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington National Cemetery, Arlington, Va.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Pennington</i>		24a. REC'D BY REGISTRAR <i>Bennie M. Thorpe</i>	
		24b. REGISTRAR'S SIGNATURE <i>Bennie M. Thorpe</i>	

RECEIVED
BUREAU Y.

JAN 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

886

CERTIFICATE OF DEATH

00877

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland	b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 3 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4407 Maple Avenue		d. STREET ADDRESS 4407 Maple Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle W	Last NAYLOR
4. DATE OF DEATH	Month Jan	Day 5	Year 19 57
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1872
9. AGE (In years lost/birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 16	11. IF UNDER 24 HRS. Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Railway Postal Clk		10b. KIND OF BUSINESS OR INDUSTRY Ret. Gov.	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Naylor		14. MOTHER'S MAIDEN NAME Elizabeth Blanchard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Sylva Cannon Daughter Dr. Green Acres, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 5015 Greenway	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		myocardial Failure	
(c) DUE TO		Generalized arterio-sclerosis years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic lymphoid leukemia	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ alive on _____		ADDRESS (Street, city or town, state) Alfred S. Norton M.D. 4711 Highland Ave. Bethesda, Md. 1/5/57	
DATE SIGNED 1/5/57			
ACTUAL SIGNATURE Alfred S. Norton		PHYSICIAN'S NAME (Type) Alfred S. Norton	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-57	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn
22d. LOCATION (Cty. town, or county) Montgomery		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE 1-8-57	24b. REGISTRAR'S SIGNATURE Bessie McHenry, Secy.
ADDRESS Bethesda, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 10 1972

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00878

887

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 14 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE District of Columbia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
						d. STREET ADDRESS 1724 27th Street, S.E.				
3. NAME OF DECEASED (Type or print) Ray		First Ray		Middle Duncan		4. DATE OF DEATH NESTER		Month January	Day 22	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-6-94		9. AGE (in years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Andrew W. Nester				14. MOTHER'S MAIDEN NAME Ruth Baxter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Wife) Eleanore G. Nester, (Same As #2)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (p) <i>Carcinoma of the Lung</i>					INTERVAL BETWEEN ONSET AND DEATH 9 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO								
{ (c)		DUE TO								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Arlington	(State) Virginia	
21. I certify that I attended the deceased from		8 Jan. 1957		to 22 Jan. 1957		that I last saw the deceased alive on 22 Jan. 1957		and that death occurred at 5:30 P.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE <i>J.T. Horgan</i>		ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 1-23-57					DATE SIGNED			
PHYSICIAN'S NAME (Type) J.T. HORGAN, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Jan. 1957		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.T. Ryan, Esq.</i>		ADDRESS 317 Penn. Ave., N.W., Washington, D.C.		24a. REC'D BY REGISTRAR 1-23-57		24b. REGISTRAR'S SIGNATURE <i>Doris L. Russell</i>				

BULLARD V. S.
LAW OFFICES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00879

888

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 159 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4710 Edgemore Lane Apt. 101		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Richard	Middle Dennis	Last NEVILLE	4. DATE OF DEATH	Month January	Day 18	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept. 1924	9. AGE (In years last birthday) 32	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James NEVILLE		14. MOTHER'S MAIDEN NAME Viola Balzel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT (Wife) Fujiko Neville (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 81X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Carcinoma of urinary bladder with liver metastases. " " " (c) DUE TO " " " " " "						INTERVAL BETWEEN ONSET AND DEATH 165 mos	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Aug. 1956, to 18 January 1957, that I last saw the deceased alive on 17 January 1957, and that death occurred at 2:22A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED Byron D. Casteel, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md. 1-18-57							
PHYSICIAN'S NAME (Type) Byron D. Casteel, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery		22d. LOCATION (City, town, or county) Cleveland, Ohio (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1-18-57		24b. REGISTRAR'S SIGNATURE Byron E. Passerly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

May 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

000880

CERTIFICATE OF DEATH

Reg. Dist. No. 16

889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Mexico		b. COUNTY Chaves	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roswell			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 59 Van Lueven Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lee	Middle Thomas	Last Newhouse	4. DATE OF DEATH January 24th, 1957	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 4, 1954	9. AGE (in years lost birthday) 2 yr.	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 20	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gordon L. Newhouse				14. MOTHER'S MAIDEN NAME Doris Bressette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 154.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Congestive Heart Failure Concurrent Heart Disease INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.p. 20d. INJURY OCCURRED p.m. While Not while 19 at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 10, 1957 , to January 24, 1957 , that I last saw the deceased alive on January 24, 1957 , and that death occurred at 7:50A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Clarence S. Weldon M.D. DATE SIGNED 1/24/57 PHYSICIAN'S NAME (Type) Clarence S. Weldon, M. D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/29/1957 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National 22d. LOCATION (City, town, or county) Baltimore (State) Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. ADDRESS VS A15 (4) 15M 9/55 24a. REC'D BY REGISTRAR DATE 1/24/57 24b. REGISTRAR'S SIGNATURE 7 Jan 11, 1957, J.W.							

REAU V.

1957

GEI V E

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00881

890 CERTIFICATE OF DEATH

Reg. Dist. No. 216

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-51 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MONTGOMERY Suburban Hospital	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND Silver Spring
		LENGTH OF STAY (In this place)	2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS 12613 17th century DRIVE		
3. NAME OF DECEASED (First) Ralph G		4. DATE OF DEATH (Month) (Day) (Year) 12 28 1957	
S. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4/6/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Radio & T.V.	9. AGE last birthday 59 yrs.
13. FATHER'S NAME Rupert Fellows Parker		11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. no	17. INFORMANT & ADDRESS Mrs. A. J. Pierson Step-daughter - 44 years
18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (A) Myocardial infarction (B) Arteriosclerotic heart disease (C) Chronic bronchitis Post traumatic epilepsy	INTERVAL BETWEEN ONSET AND DEATH 3 hours 10 years 35 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from November, 1953, to December, 19....., that I last saw the deceased alive on 1-28-1957, and that death occurred at 1:30 P.M. from the causes and on the date stated above. SIGNATURE <i>Ralph G. Fisher</i> M.D. <i>931 Pershing Drive, Silver Spring, Md.</i> DATE SIGNED <i>1-28-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transit-Burial		DATE THEREOF 1/31/57	NAME OF CEMETERY OR CREMATORIUM Cheshire Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Rosa K. Thompson	25. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey
DATE 1-30-57		ADDRESS Silver Spring, Md.	

BRUNAU Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

891

CERTIFICATE OF DEATH

011882

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
Montgomery Maryland		MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Silver Spring	28 XX years.	Silver Spring	Silver Spring		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Bonfant Street	822 Bonfant Street				
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
	WILLIAM	EMERSON	PERRY SR		
4. DATE OF DEATH	Month	Day	Year		
	JANUARY	14	1957		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS
Male	white		July 29, 1887	67 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Lawyer		Law		Ohio	
12. CITIZEN OF WHAT COUNTRY?					
U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JAMES PERRY		ANNIE NORMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		MRS MARY Dickson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Ventricular fibrillation		1316 - Post St. Read	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Coronary occlusion		Seconds.	
		DUE TO (c) Coronary atherosclerosis		15 minutes.	
19. MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH	
		Previous Myocardial infarction August 1953		5 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County) (State)	
21. I certify that I attended the deceased from January 1, 1957, to January 14, 1957, that I last saw the deceased alive on January 8, 1957, and that death occurred at 8 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		M.D. 8907 GEORGIA AVE SILVER SPRING JAN 14 James A. Roberts		DATE SIGNED MD. 1957	
PHYSICIAN'S NAME (Type)		JAMES A. ROBERTS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey,		ADDRESS SILVER SPRING, MD.		24a. REC'D. BY REGISTRAR DATE 1/15/57	
				24b. REGISTRAR'S SIGNATURE James A. Roberts	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the record or prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU Y.

AN 21 1957

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

892

00883

CERTIFICATE OF DEATH

Reg. Dist. No. 14

The correct
margin for
filling out
this form.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
LENGTH OF STAY (in this place) <u>2 yrs.</u>		STREET ADDRESS <u>9305 Parkhill Terrace</u> (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9305 Parkhill Terrace</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 22 1957</u>	
3. NAME OF DECEASED (Type or Print) <u>Oliva Vernon Fisher</u>		5. AGE last birthday If under 1 year Months Days Hours Min. <u>75 yrs.</u>	
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 25, 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Cappage</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Ellen Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>George R. Rettlinger, Jr., M.D., 2</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congestive heart failure

4 years

Antecedent cause(s)

Coronary arteriosclerotic heart disease

6 years

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>Jan. 22, 1957</u> , to <u>1-22, 1957</u> , that I last saw the deceased	ADDRESS	DATE SIGNED
alive on <u>1-22, 1957</u> , and that death occurred at <u>6:30 a.m.</u> , from the causes and on the date stated above.		

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

901-202 New York St. 1-22-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
<u>Funeral</u>	<u>1/22/57</u>	<u>Fairview</u>	<u>Cape Pepper</u>	<u>Md.</u>

DATE REC'D BY LOCAL REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>
REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>	REG. <u>1-23-57</u>

MURÉAU Y. S

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

783

CERTIFICATE OF DEATH

Reg. Dist. No.

(111884
773)

1. PLACE OF DEATH a. COUNTY Montgomery County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12, D.C.		c. LENGTH OF STAY IN 1b 1 day		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		e. STREET ADDRESS 3120 Powder Mill Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 16	
3. NAME OF DECEASED (Type or print) Mr. John		First William	Middle Quackenbush	Last January 24	4. DATE OF DEATH 1957
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/70	9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 1 Days 5 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired mechanic		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Mr. John Quackenbush		14. MOTHER'S MAIDEN NAME Catherine Rose		12. CITIZEN OF WHAT COUNTRY? Amer.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 327		17. INFORMANT Russell Quackenbush Address 7404 Hippo Hill, Takoma Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Paralysis agitans ② Cystitis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1927 , to Jan 24, 1957 , that I last saw the deceased alive on Jan 24, 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 7201 Carroll Ave 1-24-57					
ACTUAL SIGNATURE James M. Wilson		DATE SIGNED 1-24-57			
PHYSICIAN'S NAME (Type) J. Arthur Walters, 254 Carroll St. N.W. D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 27, 1957		22c. NAME OF CEMETERY OR CREMATORIUM George Washington Cemetery	
22d. LOCATION (City, town, or county) Prince George Co. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. N.W. D.C.		ADDRESS 101 W. Pratt St. Baltimore 2, Md.		24a. REC'D BY REGISTRAR JAN 28 1957	
				24b. REGISTRAR'S SIGNATURE J. Wilson Daddo	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

IAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

893

CERTIFICATE OF DEATH

00885

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orient, Long Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Navy Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Frederick	Middle Irving	Last Rackett	4. DATE OF DEATH January 8, 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 18, 1942	9. AGE (In years last birthday) 14 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frederick F. Rackett		14. MOTHER'S MAIDEN NAME Harriet Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH 60+ hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b. <i>Acute lymphocytic leukemia</i>				19. DUE TO c. <i>Gastrointestinal bleeding</i> 1 yr mas	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Gastrointestinal bleeding</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Intestinal bleeding</i>			
20c. TIME OF INJURY Month, Day, Year Hour P.M. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 3, 1957, to January 8, 1957, that I last saw the deceased alive on January 8, 1957, and that death occurred at 10:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Samuel Charache</u> M.D. DATE SIGNED <u>1/9/57</u> PHYSICIAN'S NAME (Type) Samuel Charache, M.D.					
22a. BURIAL, CREMATION, REMOVAL (SUSPENDED) Burial-Transit		22b. DATE THEREOF 1/9/57		22c. NAME OF CEMETERY OR CREMATORIAL Central Cemetery	
22d. LOCATION (City, town, or county) Long Island, New York				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 1/10/57		24b. REGISTRAR'S SIGNATURE Besie M. Thompson	

BUREAU V. S.

JAN 15 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

894 CERTIFICATE OF DEATH

00886

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Montgomery				a. STATE	New Jersey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orange		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 339 Mechanic Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Edward	Middle ---	Last Rella	4. DATE OF DEATH January 24 1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 1 yrs	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 9, 1955	IF UNDER 1 YEAR Months 5 Days 15 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Minor Child		- - - - -		New Jersey		
12. CITIZEN OF WHAT COUNTRY?				U. S. A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Stephan Rella		Angelina Cuccinello				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address		
(If yes, give war or dates of service)		None		The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Failure 3 hrs				
7 4.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)	Congenital Heart Disease, Ventricular Septal Defect 6 hrs			
{		DUE TO (c)	Heart Surgery - Post Op			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
19						
21. I certify that I attended the deceased from January 13, 1957, to January 24, 1957, that I last saw the deceased alive on January 24, 1957, and that death occurred at 6:13 P.M. from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) DATE SIGNED Theodore Cooper, M. D. 1/25/57						
ACTUAL SIGNATURE M.D. The Clinical Center PHYSICIAN'S NAME (Type) National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/1957	22c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	22d. LOCATION (City, town, or county) Morris Co.	(State) New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1/28/57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

895 CERTIFICATE OF DEATH

00887

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 1715 Minnesota Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Frederick	Middle August	Last REMUS	4. DATE OF DEATH January 13	Month Day Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1895	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Karl Remus		14. MOTHER'S MAIDEN NAME Bertha DOLLAS		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO World War I		17. INFORMANT (wife) Mildred Remus (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-7- , 1957 , to 1-13- , 1957 , that I last saw the deceased alive on 1-12- , 1957 , and that death occurred at 0423 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>William C.E. Pfischner Jr.</i> PHYSICIAN'S NAME (Type) William C.E. PFISCHNER, LCDR MC U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	
22d. LOCATION (City, town, or county) Arlington, Va.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Frank E. Russell Jr.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i>		ADDRESS 1661 Good Hope Rd, Washington DC			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please file in the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00888

896 CERTIFICATE OF DEATH

Reg. Dist. No. 244

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>56</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>204 Indian Spring Drive</i>				d STREET ADDRESS <i>204 Indian Spring Drive</i>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Marie Gertrude Robbins</i>		First	Middle	Last	4. DATE OF DEATH <i>January 9, 1957</i>	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>12/8/20</i>	9. AGE (In years lost birthday) <i>36</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Araconda, Montana</i>		12. CITIZEN OF WHAT COUNTRY? <i>204 Indian Spring Dr. S.S. Md.</i>		
13. FATHER'S NAME <i>Charles Forrester</i>		14. MOTHER'S MAIDEN NAME <i>Marie T. Greene</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>547-22-3051</i>		17. INFORMANT <i>William Warren Robbins</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO		<i>Pulmonary embolus</i>		<i>Chronic obstruction, intestines</i>		INTERVAL BETWEEN ONSET AND DEATH <i>half hour</i>		
		<i>Mass in abdomen</i>				<i>2 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 960 Colesville Rd</i>		20f. (City or town) <i>Oct 1956</i>	(County)	(State)
21. I certify that I attended the deceased from _____, 1954, to _____, 1956, that I last saw the deceased alive on _____, 1956, and that death occurred at _____, 1956, M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Silver Spring, Md.</i>	DATE SIGNED <i>1-7-57</i>	
ACTUAL SIGNATURE <i>John N. Andrews</i>								
PHYSICIAN'S NAME (Type) <i>John N. Andrews</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/11/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington, D.C.</i>		ADDRESS <i>66057</i>		24a. REC'D BY REGISTRAR <i>Frances Collier</i>		24b. REGISTRAR'S SIGNATURE		

TO ATTEND: The law requires that the death certificate be executed within 24 hours after death. Name _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page _____ should be detached for use as the burial/transit permit. Then please remove carbon papers. Page _____ and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/54

SAUVEAU V. S.

JAN 14 1964

KELVINGROVE LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00889

897

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 23 1/2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS Spring STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nannie	Middle Rodeffer		4. DATE OF DEATH January 16 1957	Month January	Day 16	Year 1957
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 2/14/76	9. AGE (In years l/m/b/birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James		14. MOTHER'S MAIDEN NAME Morrison					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Edna Hartman		Address 3623 Glenmore Dr. N.W. Wood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Cerebral Embolism				INTERVAL BETWEEN ONSET AND DEATH 15 hrs.	
DUE TO Atrial Fibrillation						25 hrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NOV 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8805 Conn. Ave		20f. (City or town) Woodstock, Va.	(County) (State)
21. I certify that I attended the deceased from 2/15 , 1956, to 4/16 , 1957, that I last saw the deceased alive on 1/16 , 1957, and that death occurred at 740 M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) Cherry Chase 15 MD	
ACTUAL SIGNATURE John B. Umhoefer						DATE SIGNED 4/16/57	
PHYSICIAN'S NAME (Type) John B. Umhoefer							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORIAL —		22d. LOCATION (City, town, or county) Woodstock, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Henries Co		ADDRESS 2901-14 1/4 St. N.W. Wash. DC.		24a. REC'D BY REGISTRAR DATE - 18-07		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIVE
BUREAU V. 2

AN 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00890
Reg. Dist. No. 26

898

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery MARYLAND		a. STATE D.C.	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Roosevelt st. + Old Georgetown Rd		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) Warren Alfred Ross		d. STREET ADDRESS 1401 Yorkinum St NW	
3. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - OWNER		10b. KIND OF BUSINESS OR INDUSTRY Elect Supply	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Ross		14. MOTHER'S MAIDEN NAME Lavinia Carl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Geo Martin		Address 5306 Hampton Way Bethesda MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE FRANK J. Broschart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-30-57
EXAMINER'S NAME (Type) FRANK J. Broschart			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 2/1/57	22c. NAME OF CEMETERY OR CREMATORIUM RT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warren L. Humphrey,	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE 1-57	24b. REGISTRAR'S SIGNATURE Bessie W. Thompson

To PUT MEDICAL EXAMINER: This certificate should be executed within 2 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transtis permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

BUREAU Y

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
899 CERTIFICATE OF DEATH

00891
276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 65 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 13106 Parkland Drive				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Jean	Middle Louise	Last Sansbury	4. DATE OF DEATH	Month January	Day 9,	Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1925	9. AGE (In years last birthday) 31 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dance Instructor			10b. KIND OF BUSINESS OR INDUSTRY Instructor of Dancing		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard Riggle				14. MOTHER'S MAIDEN NAME Stella Newick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO acute laryngeal edema INTERVAL BETWEEN ONSET AND DEATH 7 22 52 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) acute respiratory distress syndrome etc. (c) acute laryngitis 5 days										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland, Md.		(County) Calvert Co.	(State) Md.
21. I certify that I attended the deceased from November 5, 1956 to January 9, 1957 , that I last saw the deceased alive on January 9, 1957 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE D. G. Nathan, M.D. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 1/9/57										
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) Suitland, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE D. G. Nathan, M.D.					ADDRESS 13106 Parkland Drive, Bethesda 14, Maryland					
VS A15 (4) 15M 9/55					24a. REG'D BY REGISTRAR DATE 1/12/57					
					24b. REGISTRAR'S SIGNATURE Bevie Thompson					

U.S. NAVY

REGIMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00892

Reg. Dist. No. 2/14

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained by the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 16 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9708 LAWNDALE DRIVE				d. STREET ADDRESS 9708 LAWNDALE DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First B.	Middle SCHOONMAKER	Last 	4. DATE OF DEATH JANUARY 12	Month Month	Day Day	Year Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14, 1908	9. AGE (In years at birthday) 48 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY C. & P. TELEPHONE		11. BIRTHPLACE (State or foreign country) CO. D. of C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WARREN M. SCHOONMAKER			14. MOTHER'S MAIDEN NAME DAISY V. ROTHWELL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-01-0862		17. INFORMANT Mrs. Mary E. Schoonmaker, 9708 Lawndale Drive		Address Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO HANGING DUE TO Conditions, if any, which goes rise to immediate cause (b) (c) DUE TO (d) (e) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FOUND HANGING FROM BEAM IN BASEMENT OF HOME							
20c. TIME OF INJURY Hour a. m. 10:00 p. m. 1:12		Month, Day, Year A. 157	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE— <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) FRANK J. BROSCHEART		DATE SIGNED JAN. 12, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Humphrey,</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 4/2/57		24b. REGISTRAR'S SIGNATURE <i>Frank J. Broschart</i>			

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00893

Reg. Dist. No. 216

CERTIFICATE OF DEATH

991

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 84 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22-12		d. STREET ADDRESS North Salisbury Boulevard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Marguerite	Middle Taylor	Last Senter	4. DATE OF DEATH January 23rd,	Month 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1910	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Gary G. Taylor			14. MOTHER'S MAIDEN NAME Mary Ellen Newlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Record Address Not available The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Pneumonia, underlying</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>cause undetermined at present time</i> DUE TO <i>Anemia, anemia, hypertension, etc., etc.</i> (c) <i>Anemia, anemia, hypertension, etc., etc.</i>						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 31st, 1956 , to Jan. 23rd, 1957 , that I last saw the deceased alive on Jan. 23rd, 1957 , and that death occurred at 12:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>James L. German</i> M.D. 1/23/57 PHYSICIAN'S NAME (Type) James L. German, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. & Burial 1/26/57		22b. DATE THEREOF 1/26/57		22c. NAME OF CEMETERY OR CREMATORIAL New London, Indiana		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Remphrey, Silver Spring</i>			ADDRESS DATE 1-26-57		24a. REC'D BY REGISTRAR Benjamin Thompson	
VS A15 (4) 15M 9/55					24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JAN 1972

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00894

902

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN IB 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 17 Forrester, St., S.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carolyn		First Ann	Last SINCLAIR	4. DATE OF DEATH January 24 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 January 1957	9. AGE (In years lost birthday) yrs. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Thomas Sinclair		14. MOTHER'S MAIDEN NAME Ruby Wallace		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Father, Thomas Sinclair (Same As #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dehydration and hypoelectrolytemia		INTERVAL BETWEEN ONSET AND DEATH 5½ Days		
764.0 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Gastroenteritis, acute DUE TO (c)		5½ days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subarachnoid hemorrhage, frontal hemispheres, bilateral, slight.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	20f. (City or town) (County) (State) 1-25-57
21. I certify that I attended the deceased from 20 January 1957 to 24 January 1957 that I last saw the deceased alive on 24 January 1957 and that death occurred at 6:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles Waite M.D. U.S. Naval Hospital, Bethesda, Md. 1-25-57. DATE SIGNED				
PHYSICIAN'S NAME (Type) Charles Waite, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 517 11th St., S.E. Washington, D.C.		ADDRESS Chambers, 517 11th St., S.E. Washington, D.C.	24a. REC'D BY REGISTRAR 1-25-57	24b. REGISTRAR'S SIGNATURE James E. Russell

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001895

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 307 - 11th Street, S. E.				
3. NAME OF DECEASED (Type or print)		First Carrie	Middle (none)	Last Smith	4. DATE OF DEATH January	Month 29,	Year 19 57	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1905	9. AGE (In years last birthday) 51 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME James James				14. MOTHER'S MAIDEN NAME Maria Brooks				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>MAGNUTRITION</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) The Clinical Center	(County)	(State)
21. I certify that I attended the deceased from November 18, 1956, to January 29, 1957, that I last saw the deceased alive on January 29, 1957, and that death occurred at 6:50 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland								
ACTUAL SIGNATURE <i>Gurston Goldin, M. D.</i>		M.D.		DATE SIGNED 1/30/57				
PHYSICIAN'S NAME (Type) Gurston Goldin, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb-2-1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery		22d. LOCATION (City, town, or county) Caroline County, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.,		ADDRESS 901 3rd St., S. W.		24a. REC'D BY REGISTRAR DATE B 1 1957		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the remains prior to burial, cremation, or removal.

BUREAU V. S.

FEB 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 11 Film C210 1-29-57 et
CERTIFICATE OF DEATH

00896
Reg. Dist. No. 217

904

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN lb <i>over 2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Gaithersburg</i>		d. STREET ADDRESS <i>111 floral Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Montgomery County General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Edward</i>	Last <i>Sommerville Jr.</i>	4. DATE OF DEATH Month <i>Jan</i>	Day <i>19</i>	Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 1, 1950</i>	9. AGE (In years last birthday) <i>6 yrs.</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>Hours</i>	12. IF UNDER 24 HRS Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Montgomery Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>William Edward Sommerville Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Brubaker</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wm E. Sumerville. "It's certain."</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i>						INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>			
580X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Acute hepatitis</i>				5 days			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Tue 16</i> , 19 <i>57</i> , to <i>Tue 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Tue 12</i> , 19 <i>57</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Sandy Spring, Md.</i>	DATE SIGNED <i>1/12/57</i>
ACTUAL SIGNATURE <i>A. D. Bonifant</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>A. D. Bonifant</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-19-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St Rose,</i>		22d. LOCATION (City, town, or county) <i>Glo. Per.</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gartner</i>		ADDRESS <i>Jaith rsburg</i>		24a. REC'D BY REGISTRAR DATE <i>1-19-57</i>		24b. REGISTRAR'S SIGNATURE <i>Gertude Blawer</i>			

RECEIVED

JAN

1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

905

CERTIFICATE OF DEATH

00897

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5411 Roosevelt Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles B.		First	Middle	Last	4. DATE OF DEATH January 6	Month	Day	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1866 September 29,		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, U.S.Gov.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME E. Sornborger		14. MOTHER'S MAIDEN NAME Hannah Barber						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Daughter, Dorothy G. Sornborger, same as #2		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 470.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Broncho-pneumonia, hypotonic 20 to Art. Heart D. decompenated (b) Congestive H.F.: Bilateral Pleural effusion + Pericardial effusion (c)		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fractured Lt Femur + Hip mailing						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 104 Chevy Chase Dr.	(County)	(State)
21. I certify that I attended the deceased from _____ Dec. 1, 1956, to Jan 6, 1957, that I last saw the deceased alive on _____ 1/4/57, 1957, and that death occurred at 4:35A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 104 Chevy Chase Dr.		DATE SIGNED 1/6/57		
ACTUAL SIGNATURE <i>Austin B. Rohrbach</i>			M.D.					
PHYSICIAN'S NAME (Type) Austin B. Rohrbach								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/8/57	22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Shel. H. Horne Jr.</i>	ADDRESS 2901-14th & 22nd		24a. REC'D BY REGISTRAR DATE 8-57		24b. REGISTRAR'S SIGNATURE <i>Bessie McWhorter 6201</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REVIEW

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

906 CERTIFICATE OF DEATH

00898

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i>		If institution Residence before admission b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4401 Everett Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Holman C. Row Sparks</i>		First	Middle	Last	4. DATE OF DEATH Month 1 - Day 8 Year 1954				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-22-80</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Used car manager - Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>John Sparks</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NC</i>		16. SOCIAL SECURITY NO. <i>577-05-8208</i>		17. INFORMANT <i>Mabelle Sparks (wife)</i>		Address <i>Kensington, MD. 4401 Everett St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO <i>Tuberculosis Coronary Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <i>Generalized Artherosclerosis</i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus mild.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Nicholasville</i>		(County) <i>Lincoln</i>	(State) <i>Ky.</i>
21. I certify that I attended the deceased from <i>1/7</i> , 19 <i>57</i> , to <i>1/8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/8</i> , 19 <i>57</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>113 Carroll Street, Wash DC</i>		DATE SIGNED <i>1/8/57</i>	
ACTUAL SIGNATURE <i>Dean H. Harding</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Dean H. Harding</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>1/10/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Maple Grove Cemetery</i>		22d. LOCATION (City, town, or county) <i>Nicholasville, Kentucky</i>		(State) <i>Ky.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. H. Hinshaw</i>		ADDRESS <i>2901 14th Street N.W.</i>		24a. REC'D. BY REGISTRAR DATE <i>11 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>			

Bullard A. E

DN 7-1965

1965-10-17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00899

907

CERTIFICATE OF DEATH

Reg. Dist. No.

216

PLACE OF DEATH

o. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)
Chevy Chase 15

4 1/4 yrs.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Montgomery

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

7002 Brookville Road

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase 15

d. STREET ADDRESS

7002 Brookville Road

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS

Male

White

WIDOWED DIVORCED

Feb. 24, 1875

81 yr.

11 months

4 days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10b. KIND OF BUSINESS OR INDUSTRY

Retired ???

11. BIRTHPLACE (State or foreign country)

Camden Co. N. Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Stevens

14. MOTHER'S MAIDEN NAME

Emma Jane Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(For, no, or unknown)

No

16. SOCIAL SECURITY NO.

228-18-7540

17. INFORMANT

Mrs. Harry Irvine-Same Item #2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

420.1

DUE TO

Acute Cardiac failure

INTERVAL BETWEEN
ONSET AND DEATH
15 hrs.Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Chronic arteriosclerosis

10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)19. WAS AUTOPSY
PERFORMED
YES NO

Cerebral edema of the Esophagus

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 5-20-1957 to 1-28-1957 that I last saw the deceased alive on 1-27-1957 and that death occurred at 5:30 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D. 37, Connecticut, D.C. 1-28-57

PHYSICIAN'S
NAME (Type) C. Roger Kurtz, M.D.

3701 Conn. Ave. N. W., Washington, D. C.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Bur-transit

22b. DATE THEREOF
1/30/1957

22c. NAME OF CEMETERY OR CREMATORIUM

Memorial

22d. LOCATION (City, town, or county)

(State)

Warwick Co., Va.

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
Robert A. Pumphrey-7557 Wis. Ave. Bethesda Md

24a. REC'D BY REGISTRAR

DATE 1-24-57

24b. REGISTRAR'S SIGNATURE

12 sin 11. monson

LEAD V. 8

JUN 25 1957

LEADVILLE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00900

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 and 6 should be used as a burial-transit permit. File pages 1, 2 and 3 with the **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the **BURIAL DIRECTOR:** Page 6 prior to burial, cremation.

1. PLACE OF DEATH a. COUNTY		908 Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Glen Echo		d. STREET ADDRESS 6826 Waukesha Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6826 Waukesha Rd.				d. STREET ADDRESS 6826 Waukesha Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Agnes	Middle Stewart	4. DATE OF DEATH	Jan. 11, 1957	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
female	col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 23, 1892	65 61 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Mose Hopkins		14. MOTHER'S MAIDEN NAME Charlotte Kinslow						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lillian Hart Address 6826 Waukesha Road., Glen Echo, Md.				
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH Found dead In bed		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		History of previous C.V.A.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE	<i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)	Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL CREMATION		22b. DATE THEREOF Burial 1/16/57	22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Cemetery		22d. LOCATION City, town, or county Suitland, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co.		ADDRESS 1432 You ST. N.W.		24a. REC'D BY REGISTRAR Date 15/57	24b. REC'D BY DIRECTOR'S SIGNATURE Date 15/57	<i>Ressie Thompson</i>		

BUREAU V.

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

909

CERTIFICATE OF DEATH

00901
274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>6 mo</i>	b. COUNTY <i>Montgomery</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, MD</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10,001 GEORGIA AVENUE</i>	d. STREET ADDRESS <i>10,001 Georgia Ave</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Julia</i>	First <i>Ann</i>	Middle <i>Stout</i>	Last <i>January 31 1957</i>
4. DATE OF DEATH <i>Oct. 22, 1956</i>	Month <i>January</i>	Day <i>31</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 22, 1956</i>
9. AGE (In years lost birthday) yrs <i>3</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>9</i>	12. Hours <i>Min</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry W. Stout</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Anna Mc Mahon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Address</i>	
17. INFORMANT <i>Henry W. Stout, Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Bilateral pneumonia</i>			
DUE TO <i>Pyelo nephritis -</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/22</i> , 19 <i>56</i> , to <i>1/24</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/24</i> , 19 <i>57</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Herbert D. Glick M.D. 8301 Penny Branch Rd - Sil. Spr., Md.</i>			
ACTUAL SIGNATURE <i>Herbert D. Glick</i>		DATE SIGNED <i>1/24/57</i>	
PHYSICIAN'S NAME (Type) <i>Herbert D. GLICK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2/2/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. JOHN'S CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren C. Humphrey,</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>1/24/57</i>
			24b. REGISTRAR'S SIGNATURE <i>Francois Miller</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

FEB 5 1957

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

910

CERTIFICATE OF DEATH

00902
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Montgomery Co. Kensington - Mont. Cty. MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		W. Hyattsville Md 1675-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Kensington Garden San.		5844 Jamestown Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
			4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 19 1978
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter		Carpenter	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Georgia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William E. Swanson		Sarah O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 14-11-01(14-11-04)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
		Robert Swanson 5844 Jamestown Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) Arteriosclerosis benign DUE TO Devi.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1956, to Nov. 22, 1957, that I last saw the deceased alive on 1/17/57, 19, and that death occurred at 6:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Kensington, Md. DATE SIGNED	
ACTUAL SIGNATURE James S. Allen, M.D.		Kensington, Md. 1/25/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-25-1957	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Neal Funeral Home 4812 Georgia Ave. N.W.		24a. REC'D BY REGISTRAR Frances Patterson DATE 1/25/1957	
ADDRESS Wash. D.C.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUREAU Y.

1957

TRADE SHOW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00903

911 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Baltimore City</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN lb <i>9 4 p.m.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Luke's Hospital</i>		d. STREET ADDRESS <i>1617 31st Street, N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Frank C. L.</i>	Middle <i></i>	Last <i>THOMPSON</i>	4. DATE OF DEATH <i>1-11-57</i>	Month <i>Jan.</i>	Day <i>11</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-57</i>	9. AGE (In years last birthday) <i>6 months</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Bethesda, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Theodore Sidney Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Schmidley</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>None</i>		Address <i>1617 31st Street, N.W., Bethesda, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		DUE TO <i></i>				INTERVAL BETWEEN ONSET AND DEATH <i></i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) <i>Pneumonia</i>					
(c) <i>Pneumonia, Cerebral</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 22, 1957</i> to <i>Jan 22, 1957</i> that I last saw the deceased alive on <i>Jan 22, 1957</i> , and that death occurred at <i>2:05 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1617 31st Street, Bethesda, Maryland</i> DATE SIGNED <i>Michael L. Buckley, M.D.</i>							
ACTUAL SIGNATURE <i>Michael L. Buckley, M.D.</i>							
PHYSICIAN'S NAME (Type) <i>Michael L. Buckley, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 24-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Montgomery Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Poolesville, Mont. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>1-23-57</i>		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YUREAU

AN 22 1957

REVIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

912

CERTIFICATE OF DEATH

00904

Reg. Dist. No. 216 ✓

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 3 months		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 E. SCHUYLER ROAD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TUNNELTON		d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First JOHN	Middle J.	Last TOBIAS	4. DATE OF DEATH	Month JAN.	Day 16	Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH OCT. 15, 1887		9. AGE (In years less birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. M'n. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BUDAPEST HUNGARY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN TOBIAS		14. MOTHER'S MAIDEN NAME JULIA VASVARY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 235-09-0233		17. INFORMANT MRS. ELIZABETH STEIN, 207 E. Schuyler Road		Address Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMA OF STOMACH				INTERVAL BETWEEN ONSET AND DEATH 1 YEAR		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 9013 Flower Ave (State) SILVER SPRING, MD.		
21. I certify that I attended the deceased from OCT. 1957 , to 1-16 , 1957 , that I last saw the deceased alive on 1-15 , 1957 , and that death occurred at 3A , M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 11/16/57		DATE SIGNED				
ACTUAL SIGNATURE L.B. Snow		M.D.						
PHYSICIAN'S NAME (Type) L. B. SNOW								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Lumpprey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1-17-57		24b. REGISTRAR'S SIGNATURE Franklin H. ...		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

BUREAU V.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

913

CERTIFICATE OF DEATH

00905

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Ranier							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4530 32nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frank		First Frank	Middle Lynn	Last TRACY	4. DATE OF DEATH January	Month January	Day 22	Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 1887	9. AGE (In years last birthday) 69	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S. MarCor (Retired)		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Frank TRACY				14. MOTHER'S MAIDEN NAME Angeline BEEMAN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. U.S. Naval Hospital, Bethesda, Md.		20f. (City or town) Washington, D. C.		(County) D.C.	(State) D.C.		
21. I certify that I attended the deceased from 12 January , 19 57 , to 22 January , 19 57 , that I last saw the deceased alive on 21 January , 19 57 , and that death occurred at 02:45 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 1210 14th St., N.W. Washington, D.C.	DATE SIGNED 1-22-57
ACTUAL SIGNATURE <i>R.G. Williams</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 1-22-57									
PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.		(State) D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Max W. Hines, Jr.</i>		ADDRESS S.H. Hines, 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR 1-22-57		24b. REGISTRAR'S SIGNATURE <i>Henry E. Gisselby</i>					

BUREAU V. S.

JAN 11 1968

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

914

CERTIFICATE OF DEATH

00906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 24 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9318 Sudbury Road		e. STREET ADDRESS 9318 Sudbury Road	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RUTH	Middle C.	Last TUNIS
4. DATE OF DEATH	Month JAN.	Day 12	Year 19 57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1898
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) DETROIT, MICHIGAN
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JESSE STOUT CHIPMAN		14. MOTHER'S MAIDEN NAME MARY LOUISE CASWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mr. Henry M. Tunis, 9318 Sudbury Road		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		<i>Carcinomatosis, intra-abdominal</i>	
(c) DUE TO		<i>Carcinoma, colon(recto-sigmoid) 24 yrs.</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. , 1956, to Jan. 12, 1957 , that I last saw the deceased alive on Jan. 8, 1957 , and that death occurred at 3 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Philip H. Varner PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 10,620 8th Ave., Silver Spring, Md. DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 1/15/57	22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Warren L. Pumphrey		24a. REC'D BY REGISTRAR DATE 1/15/57	24b. REGISTRAR'S SIGNATURE Philip H. Varner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

1. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

915

CERTIFICATE OF DEATH

011907
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>6 1/2 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DISTRICT OF COLUMBIA</i>		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>					
						d. STREET ADDRESS <i>3342 Shuyerant Place N.W.</i>					
3. NAME OF DECEASED (Type or print) <i>Victoria Briggs</i>		First	Middle	Last	4. DATE OF DEATH <i>TURNER</i>	Month	Day	Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-29-73</i>		9. AGE (In years lost birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Eva moree</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>					
13. FATHER'S NAME <i>George A. Briggs</i>		14. MOTHER'S MAIDEN NAME <i>Helen M. Baker</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>		17. INFORMANT <i>Jessie Kornblub (wife)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>Generalised arteriosclerosis</i>					
						INTERVAL BETWEEN ONSET AND DEATH <i>14 hours</i>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Left cerebral embolism with aphasia</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(City or town)</i> <i>(County)</i> <i>(State)</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Stewart Clapp</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24. REC'D BY REGISTRAR <i>Date 1-10-67</i>		25. REGISTRAR'S SIGNATURE <i>Beasie M. Thompson</i>			
		22b. DATE THEREOF <i>1/12/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect Hill</i>		22d. LOCATION (City, town, or county) <i>Front Royal, Virginia</i>		(State)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

AN 15 1957

REGISTRATION

C H T

M.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

784

CERTIFICATE OF DEATH

00908
773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Montgomery</i>				a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>12 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i>		d. STREET ADDRESS <i>1914 Connecticut Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Kathryn</i>		First <i>Kathryn</i>	Middle <i>Freight</i>	Last <i>Underhill</i>	4. DATE OF DEATH <i>January 28</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 9, 1880</i>	9. AGE (In years, months, days) <i>76 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done) during most of working life even if retired) <i>H-Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>Wesley Freight</i>		14. MOTHER'S MAIDEN NAME <i>Helen Stowe</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Cancer of the lung		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1, 1956</i> to <i>Jan 28, 1957</i> that I last saw the deceased alive on <i>Jan 28, 1957</i> , and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>18th St N.W., Wash. D.C.</i>	
ACTUAL SIGNATURE <i>Edward Adelson</i>		M.D. <i>1302</i>		DATE SIGNED <i>1/29/57</i>	
PHYSICIAN'S NAME (Type) <i>Edward Adelson</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/31/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co., Wash. D.C.</i>		ADDRESS <i>N 31 1957</i>		24a. REC'D BY REGISTRAR <i>J. Wilson Adles</i>	
				24b. REGISTRAR'S SIGNATURE	

BUREAU V. S

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
916 CERTIFICATE OF DEATH

00909

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) b. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 8 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1701 20th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Grace	Middle Beryl	Last VESTAL	4. DATE OF DEATH Month January	Day Year 26 19 57				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 22 Jan. 1888	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Vincent Vestal			14. MOTHER'S MAIDEN NAME Nanne Pride						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 11-26-21 to 1-7-44 (Unknown)			17. INFORMANT Official Navy Records			
						Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			<i>tymphosarcoma</i>			INTERVAL BETWEEN ONSET AND DEATH 10 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 20 May 1956 , to 26 Jan. 1957 , that I last saw the deceased alive on 26 Jan. 1957 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>W.D. Hooper</i>			M.D. U.S. Naval Hospital, Bethesda, Md. 1-28-57						
PHYSICIAN'S NAME (Type) W.D. HOOPER, LT, MC, USN			U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>			ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 1-28-57			24b. REGISTRAR'S SIGNATURE <i>George E. Casselly</i>

IREAU V. S.

JAN 22 1968

GEORGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

917

CERTIFICATE OF DEATH

00910

Reg. Dist. No. 2/2

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick		10-11-2 Frederick d. STREET ADDRESS 711 N Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Betty		First Jane	Middle Walters
4. DATE OF DEATH Month January		Day 19	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 22 1928
9. AGE (In years lost birthday) 28		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 28 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George E. Walters		14. MOTHER'S MAIDEN NAME Catherine Ann Tobery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mr George E Walters (Same as item # 2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Disseminated Sclerosis DUE TO 45X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Nov 1956 to 19 Jan 1957 , that I last saw the deceased alive on 19 Jan 1957 , and that death occurred at 321 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) BARNESVILLE, Md. DATE SIGNED 1-19 57	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/57	
22c. NAME OF CEMETERY OR CREMATORIAL Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R.Ftchison & Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE 1/22/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00911

792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 301 N. Adams Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 N. Adams Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Benjamin	Middle nmi	Last WEISS	4. DATE OF DEATH January 18	Month January	Day 18	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 27, 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR 9 Months	IF UNDER 24 HRS 21 Days	Hours 0	Min
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Nat. Inst. Health		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) W. W. I.		16. SOCIAL SECURITY NO. 087-16-4245		17. INFORMANT Clinical Center Records-Bethesda, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) } DUE TO (d) } Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 5-10 min	
		Coronary Occlusion						5-10 min	
		Previous coronary thrombosis						2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____ May 17, 1957 to Jan 18, 1957 that I last saw the deceased alive on _____ 1-17, 1957, and that death occurred at 11:57 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W. G. Hall, M.D.								ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/1957		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn		22d. LOCATION (City, town, or county) Rockville		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DATE 1/22/57		24b. REGISTRAR'S SIGNATURE Dorrell Kragtop			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and by the funeral director, if retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

BUREAU V. S

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

00912

Reg. Dist. No. 215

918

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 50 minutes			b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
3. NAME OF DECEASED (Type or print)			First George	Middle Hubert	Last WHEELER	4. DATE OF DEATH	Month January	Day 20	Year 19 57
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-86	9. AGE (In years lost birthday) 70	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Days 0	13. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy(Retired)	11. BIRTHPLACE (State or foreign country) South Carolina					
13. FATHER'S NAME Fred Wheeler			14. MOTHER'S MAIDEN NAME Isabella Aubinoe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW-I&II	17. INFORMANT (Brother) James H. Murphy (Same As #2)	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1			INTERVAL BETWEEN ONSET AND DEATH 1 hr.						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia		
21. I certify that I attended the deceased from 20 January, 19 57 to 20 January, 19 57 , that I last saw the deceased alive on 20 January, 19 57 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-21-57									
ACTUAL SIGNATURE <i>Wiley R. Smith</i>			M.D.						
PHYSICIAN'S NAME (Type) Wiley R. Smith, LT, MC, USN			U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 24 Jan. 1957	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington	(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chambers</i>			ADDRESS 517 11th St. S.E. Washington, D. C.	24a. REC'D BY REGISTRAR 1-21-57	24b. REGISTRAR'S SIGNATURE <i>Franklin L. Fassell</i>				

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
919 CERTIFICATE OF DEATH

00913

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>	c. LENGTH OF STAY IN 1b <i>10 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Naval Gun Factory</i>		d. STREET ADDRESS <i>Robert Wills</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Robert Wills</i>	First <i>Robert</i>	Middle <i>Wills</i>	Last <i>Retired</i>	
4. DATE OF DEATH <i>11-17-57</i>	Month <i>Nov</i>	Day <i>17</i>	Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-22</i>	
9. AGE (in years lost birthday) yrs. <i>35</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	
13. CITIZEN OF WHAT COUNTRY <i>United States</i>	14. FATHER'S NAME <i>Robert Wills</i>			
15. MOTHER'S MAIDEN NAME <i>Sullivan</i>	16. SOCIAL SECURITY NO. <i>110-17-1234</i>			
17. INFORMANT <i>John J. Sullivan</i>	Address <i>4961 Battery Lane, Bethesda, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Diabetes mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Prostatitis & cystitis</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <i>Injury in Port I or Port II of item 18.</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4961 Battery Lane</i>	20f. (City or town) (County) (State) <i>Bethesda, Md.</i>	
21. I certify that I attended the deceased from <i>Oct</i> , 19 <i>57</i> to <i>Jan</i> , 19 <i>58</i> that I last saw the deceased alive on <i>11-17-1957</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Charles Savarese Jr.</i>	M.D. <i>4961 Battery Lane</i>	ADDRESS (Street, city or town, state) <i>Bethesda, Md.</i>	DATE SIGNED <i>11-17-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/21/1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		ADDRESS <i>2901 14th St., N.W. Washington, D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>1-21-57</i>	24b. REGISTRAR'S SIGNATURE <i>Bessie M. Slavin, Reg.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JAN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00914

920

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION Suburban Hospital		d. STREET ADDRESS 4629 Reseda Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle WIRDEZK	Last Month Day Year JAN. 9 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1857
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Austria-Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME KOBLOBSKY		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, labor DUE TO 331X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident DUE TO 9 days			
(c) Hypertension & arteriosclerosis 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1957 to Jan. 1957 , that I last saw the deceased alive on Jan. 1957 , and that death occurred at 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Byrd		ADDRESS (Street, city or town, state) M.D. 7657 Georgetown Rd.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 9 Jan 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 10, 1957		22b. DATE THEREOF Jan. 10, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Dove Funeral Home
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Dove Funeral Home - Byrd E.B. Arlington		24a. REC'D BY REGISTRAR 10-10-57	24b. REGISTRAR'S SIGNATURE Rosie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

IAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00915

921

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE	
Montgomery MARYLAND		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson R.F.D. #1	c. LENGTH OF STAY IN 16 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, R.F.D. #1	
		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cora	Middle B.	Last Wood
4. DATE OF DEATH	Month Jan.	Day 29	Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White		Aug. 27, 1873
9. AGE (In years lost birthday) 83 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryville, Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Frank H. Thomas	Bethaney Dennis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address 9810 Georgia Ave Silver Spring, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIAL HYPERTENSION DUE TO (c) ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH TEN DAYS 15 YEARS 20 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>JANUARY 24</u> to <u>JANUARY 29</u> , 1957, that I last saw the deceased alive on <u>JANUARY 27</u> , 1957, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gordon L. Rosenberg M.D. 26 N. Summit Bks Gordon L. Rosenberg, M.D. ADDRESS ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)			
DATE SIGNED 24 Jan 1957 Githersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-1-67 -	22c. NAME OF CEMETERY OR CREMATORIAL Forest Oaks Cemetery	22d. LOCATION (City, town, or county) Gaithersburg, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE, Ernest C. Gauthier	ADDRESS Gaithersburg, Md.	24a. REC'D BY REGISTRAR DATE Feb 1/1957	24b. REGISTRAR'S SIGNATURE Della N. Burdette

BUREAU Y.

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00916

Reg. Dist. No. 215

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W D.C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)		c. LENGTH OF STAY IN 16 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 477		d. STREET ADDRESS 4000 CATHEDRAL AVE N.W.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLOTTE		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
L.			WOODWARD		JANUARY	18	19	57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JANUARY 6 1889	9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CAL.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CARL C. LINNE				14. MOTHER'S MAIDEN NAME KATHLEEN OREILLY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — —				16. SOCIAL SECURITY NO. Unknown		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. 716.c (b) 1st 2nd 3rd DEGREE BURNS INVOLVING ABOUT 70 % DUE TO OF BODY (c)								
INTERVAL BETWEEN ONSET AND DEATH 10 DAYS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRESSING GOWN CAUGHT FIRE AT HOME						
20c. TIME OF INJURY Month, Day, Year Hour a. m. ? p. m. 1-6 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) WASHINGTON D.C.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) FRANK J. BROSCHEART		1-18-57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington (State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph GAWLER'S & SONS		ADDRESS 1756 Penna. Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR DATE 1-19-57		24b. REGISTRAR'S SIGNATURE <i>Henry E. Russell</i>		

RECEIVED
BUREAU V. S.

JAN 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111917

785

CERTIFICATE OF DEATH

Reg. Dist. No.

226

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Tikoma BK</i>	<i>20 days</i>	<i>Montgomery</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Washington Sanitarium - Hospital</i>		<i>Silver Spring</i>	
d. STREET ADDRESS		302	
<i>8716 Colesville Rd. Apt.</i>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Robert Nutt Woolard</i>			
4. DATE OF DEATH	Month	Day	Year
	1	31	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>M</i>	<i>Ca</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>7-7-71</i>
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
<i>85 yrs</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Grocer</i>	<i>Grocery</i>	<i>Virginia</i>	<i>Amer.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Thomas Woolard</i>	<i>Elizabeth Bell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>	<i>577-05-8279-1</i>	<i>Hospital record</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE			
<i>Carcinoma of Bladder & extensive metastasis</i>			
181X			
DUE TO			
<i>Terminal Uremia</i>			
DUE TO			
<i>Advanced arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
<i>6 yrs 2 mos</i>			
<i>3 wks.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 10, 1948</i> to <i>Dec 5, 1957</i> , that I last saw the deceased alive on <i>Jan 31, 1957</i> , and that death occurred at <i>914 Ellsworth St.</i> M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED <i>1-31-57</i>			
ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i>			
PHYSICIAN'S NAME (Type) <i>KENNETH F. LAUGHLIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF	
<i>2/4/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM	
<i>CEDAR HILL CEMETERY</i>		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
<i>Kenneth F. Laughlin</i>		<i>J. Wilson Dodd</i> <i>2-2-57</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
<i>Silver Spring Md.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

FEB 5 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00918

923

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 mos. 22 days		b. COUNTY District of Columbia				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
3. NAME OF DECEASED (Type or print) Ray		First Frederick	Middle YAGER	Last YAGER	4. DATE OF DEATH January 7 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 24 October 1899	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joel W. Yager				14. MOTHER'S MAIDEN NAME Estella Stucy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 2-20-35701-7-57		17. INFORMANT Mrs. Alice E. Yager (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162x		DUE TO Bronchogenic Carcinoma c metastasis				INTERVAL BETWEEN ONSET AND DEATH 1 year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p.m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 15 Aug. , 19 56 , to 7 Jan. , 19 57 that I last saw the deceased alive on 7 Jan. , 19 57 , and that death occurred at 11:00P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>R.J. McCarthy</i>			M.D. U.S. Naval Hospital, Bethesda, Md. 1-8-57					
PHYSICIAN'S NAME (Type) R.J. MC CARTHY, CDR, MC, USN			U.S. Naval Hospital, Bethesda, Md. 1-8-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-11-57	22c. NAME OF CEMETERY OR CREMATORIUM ODD Fellows Cemetery	22d. LOCATION (City, town, or county) Carrollton, Kentucky		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pimphrey</i>	ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR 1-8-57		24b. REGISTRAR'S SIGNATURE <i>Frank E. Russell</i>				

To HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU U. S.

JAN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

924

Item 9 Film G209 1-21-57 et

CERTIFICATE OF DEATH

00919
Reg. Dist. No. at 6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
<i>Montgomery</i>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10314 Fawcett St.</i>		d. STREET ADDRESS <i>10314 Fawcett St.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Martha</i>		First <i>M</i>	Middle <i>Zimmerman</i>			
4. DATE OF DEATH <i>Jan 10 1957</i>		Last <i>?</i>	Month <i>Jan</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Approx. 82 yrs.</i>		9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State of foreign country) <i>Catskill N.Y.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>						
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mr. R.F. Green - Kensington Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>				
DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Carcinoma of left breast</i>		DUE TO <i>4/20 (c)</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9241 Col. Island</i>	20f. (City or town) <i>Green Co., New York</i>	(County) <i>Col. Island</i>	(State) <i>N.Y.</i>
21. I certify that I attended the deceased from <i>10/30/53</i> , 19 <i>—</i> , to <i>4/10/57</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>Jan 9 1957</i> , and that death occurred at <i>7:50</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>9241 Col. Island</i>	DATE SIGNED <i>1/10/57</i>	
ACTUAL SIGNATURE <i>J. Marion Bankhead M.D.</i>						
PHYSICIAN'S NAME (Type) <i>J. Marion Bankhead</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-Transit</i>		22b. DATE THEREOF <i>1/11/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Jefferson Rural Cem.</i>	22d. LOCATION (City, town, or county) <i>Green Co., New York</i>	(State) <i>N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Maryland</i>		ADDRESS		24c. REC'D BY REGISTRAR <i>Date -10-57</i>	24d. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

RECEIVE

JAN 15 1957

BUREAU V. S.